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THE PROCESS

1.1 Forming a Process Based on Partnership

This report is the first attempt in 40 years to change the overall structure of the IHS to make it work better for Indian people. The process to develop this report is based on an active partnership with and participation by Indian people to reflect Indian Country priorities. It is the first time that Indian people have guided the process to design a health care system that works best for them.

1.2 Recognizing the Need for Change

The primary concern of those involved in preparing this report is to avoid being overtaken by external national forces responding to priorities different from those of Indian people. One apparent reason for change is the shift in how health care is delivered to Indian people. More tribes are taking over the delivery of health care through Self-Determination contracts and Self-Governance compacts. The Agency is assisting tribes in providing health care in their communities. One-third of the Agency's resources goes to tribes to deliver health care through contracts and compacts. Another reason is the changing health care industry--it is costlier to provide care and the technology is different and more complicated.

The Director, IHS, presented these issues to the participants of the 1994 Tribal/IHS Consultation Conference held in November in Albuquerque, New Mexico. Smaller sessions were held at the Conference to continue the dialog

about these issues and to listen to the participants' concerns.

Figure 1

1.2.1 QM Workgroup on Restructuring the IHS

The IHS first discussed restructuring the Agency in 1993 when it established the Quality Management Workgroup on Restructuring. The workgroup found that Agency restructuring was needed and that is should be pursued. The idea was revisited when Dr. Michael H. Trujillo, M.D., M.P.H., became the Director, IHS, in April 1994. He formed his vision statement soon after reviewing the work done previously. His vision statement encourages the pursuit of a better health care system for Indian people. This vision statement supports the design of a new IHS; not just restructuring what is already in place.

1.2.2 Director's Vision for a New IHS

Dr. Trujillo informed Indian Country and IHS employees of his vision for a new IHS in October 1994. His vision is for a new IHS that is the best primary care rural health system in the world. His view of change is that it is an opportunity. An opportunity caused by the changing expectation of Indian people and an era of Federal government downsizing and increasing health care costs. His vision

statement describes an administration with fewer layers that operates more efficiently and a reduced number of Federal employees. Positions and staff should be placed at levels delivering direct care, preventive care, and public health activities. The Director's vision describes change as an opportunity to improve the quality of care for Indian people.

1.3 Empowering a Partnership Process

Organizational change is best accepted when it is the product of the people that perform the work and the people who use the service. This report reflects the needs and priorities of the primary stakeholders in Indian health care--Indian people, tribal leaders, and IHS employees. Indian people have guided this process because they are the users of the service. People performing the work in the IHS have suggested some of the changes recommended in this report.

Streamlining a 40-year-old organization is a tremendous task. Simplifying the work of delivering health care services to 1.4 million people is challenging. Redeploying a workforce of 14,000 Federal employees and $2.2 billion budget to best meet local needs is a complex undertaking. Finding ways to support increased tribal control for more than 500 sovereign nations is demanding. Adapting the Indian health system to prepare for reforms occurring in national and state health care environments is a formidable job.

Figure 2

This report was designed mostly by Indian people representing their rural and urban communities. Of the 29 persons guiding the report's development, 22 are Tribal and/or urban Indian program representatives. Chairs for this group are all members of Indian tribes and accepted to be co-chairs with equal leadership

Figure 3

authorities and responsibilities.

All the IHDT debates and discussions follow a set of ground rules. These rules include listening to everyone's ideas and concerns and respecting their views. No idea, solution, or proposal is adopted if there is one opposing IHDT member. All decisions are made by consensus. Acceptance of decisions is not attained by voting. Acceptance is gained by coming to a common understanding with each other.

To empower partnership, two-way communication is included in the process to link stakeholders to the design work. The process includes submitting the work as it is being done to stakeholders and obtaining their feedback. The feedback obtained at each step is incorporated into the work as it is performed. Design activities are communicated to stakeholders through a newsletter; Congressional briefings; Tribal Leader letters; IHS Area Offices; the National Indian Health Board (NIHB); and other major tribal organizations. The national Indian news media receives the newsletter and may contact the IHS Office of

Communications for additional media information packages.

1.3.1 An Indian Health Design Team is Formed

To start a process that ensures partnership and includes primary stakeholders in Indian health care, the Director asked a group of stakeholders to discuss what they believed should be done. The IHDT was formed in January 1995 and held its first meeting in February 1995. When the Director, IHS, spoke at one of the IHDT meetings, he said:

> *"I am strongly committed to ensuring stakeholder involvement in the IHDT process because I attribute the Agency's strength to its partnership with Tribes, Indian health organizations and Indian people. The redesign of the Agency must involve the Tribes, Indian organizations and Indian people, as the principal stakeholders, from the beginning of the process. I want the changes proposed under the redesign to reflect Indian needs and priorities. I would point out that how Indian Country, the Administration and the Congress ultimately view the final proposal will be shaped and influenced by the knowledge that the principal stakeholders in the Agency played a significant role in the development of the new Agency design plan."*

1.3.2 Guiding Principles are Adopted

The IHDT design process is a self-guided process. The IHDT members set principles that would steer them in a common direction and instill unity. The principles guide the IHDT's discussions, findings, and recommendations in this report. The guiding principles are:

- **PATIENT CARE COMES FIRST**
- **BE CUSTOMER-CENTERED**

  Being customer-centered shall become a core value in the mission of all Indian organizations along with the IHS. Customers include all people, tribes, and other Indian organizations dependent on a program's services.

- **FOCUS ON HEALTH**

  Clinical, public health, and administrative functions shall be focused to promote high quality and cost effective patient care services. Any savings resulting from redesign shall be directed to patient care.

- **SOVEREIGNTY**

  The Federal government shall honor, uphold, protect, and advocate inherent sovereign rights and rights of the AI/AN Nations as evidenced by the treaty signing process, the content of those signed treaties by the signatory parties, and as afforded by the U.S. Constitution, Treaties, U.S. Statutes, Treaty Cessions, State Constitutional Disclaimer Provisions, Agreements, International Declarations of Indigenous Peoples Rights and Executive Orders.

- **CULTURAL SENSITIVITY**

  Structure, programs, and services shall be designed in partnership to respect cultural diversity at the local level.

- **TRUST RESPONSIBILITY**

  The Federal government has the trust responsibility to provide health services to Indian people.

- **EMPOWERMENT/ADAPTABILITY**

  Sufficient decision making autonomy shall exist at the local level to enable capacity to address service delivery needs.

- **ACCOUNTABILITY**

  Accountability systems shall be designed to ensure efficiency, effectiveness, and patient and customer satisfaction regarding the achievement of IHS' primary mission involving patient care, health promotion, and advocacy for tribal governments and Indian organizations.

- **TREAT EMPLOYEES FAIRLY**

  Employees shall be treated fairly and compassionately in all changes in the structure and programs of Indian health programs.

- **EXCELLENCE**

  Commitment to excellence shall be achieved and maintained in administrative, clinical, and public health programs and practices.

- **SYSTEM-WIDE SIMPLIFICATION**

  Administrative requirements and systems shall be simple and efficient for all Indian health programs.

- **FULL DISCLOSURE and CONSULTATION**

  The IHDT products shall be provided to stakeholders. Consultation shall be undertaken with tribes and Indian organizations to achieve knowledgeable participation in decision making.

These principles were submitted for feedback in March 1995 to the stakeholders in Indian health.

1.3.3 A New Mission and Goal is Proposed

The IHDT assigned a subgroup to review the existing IHS mission and goal. Nine persons representing tribal and urban health programs and IHS employees met to determine if the existing mission and goal were still appropriate for the changing demands on the IHS. The subgroup determined that the existing IHS mission statement no longer fit. The subgroup proposes that the mission of the IHS be targeted on Indian people and the state of their health. The subgroup proposes that the following statement best fits the needs and priority of Indian people and, therefore, the health system that serves them:

MISSION

The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.

The subgroup reviewed the existing goal statement for the IHS and determined that it was a better mission statement than goal statement. The subgroup proposes the following as the goal statement for the new IHS:

GOAL

To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to all American Indian and Alaska Native people.

The subgroup also added a new statement reflecting the basis of the unique relationship with Indian Nations:

FOUNDATION

To uphold the Federal government obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

In developing the proposed mission and goal statements, the subgroup checked the commonly accepted criteria that most organizations follow. The wording is specific to an organization that serves Indian people and assists them in delivering their own health care. The subgroup submitted their proposals in April 1995 to stakeholders for feedback.

1.4 The Design Process

The process for designing a new Indian health system is based on inclusion, participation, and openness with the stakeholders in Indian health care. As mentioned previously, the process includes two-way communications. The goal of two-way communications is to ensure openness and to facilitate feedback. The report refers to communication activities at each step in the process.

1.4.1 A Process is Adopted

To design a new IHS, a two-tiered approach is practiced by the IHDT. The first tier focuses on a total Indian health care system and guides the overall design process. This tier was composed of 29 stakeholders. Their names were communicated to IHS Areas in January 1995 for submission to tribal leaders to seek concurrence with the appointments. The first tier ensures a way for communicating the design process and its products to all levels of the Indian health care system--Tribal, Agency, and urban Indian leaders and staff and the Indian people. They also ensure that communications would include the HHS and the Congress.

The second tier established by the IHDT is a support level. This support level is made up of 42 persons assigned to six workgroups, called Tier II workgroups. Arranging the work into workgroups made a large amount of work more manageable. The six workgroups represent broad operational areas of the existing Indian health care system and those areas that most likely will be part of the new system.

Tier II workgroup members are stakeholders knowledgeable in the areas to which they are assigned. They are health care providers and administrators

serving Indian people at multi-levels of the Indian health care system. These workers represent all four types of Indian health care delivery--urban Indian

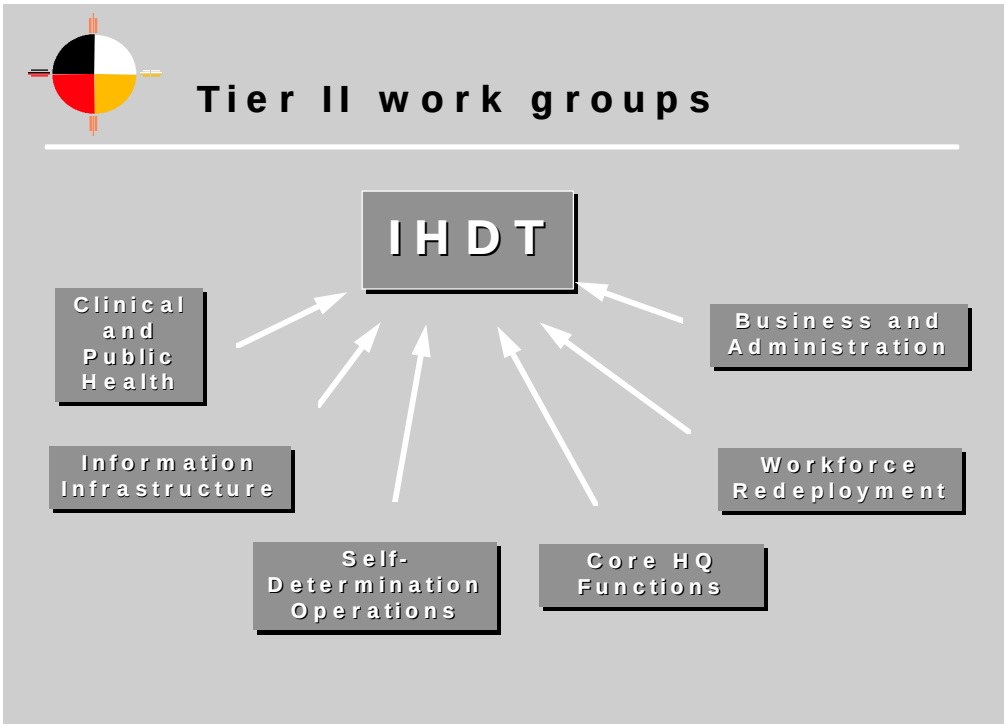

Figure 5

programs, Federal direct, and tribal compactors and contractors. The roster of workgroup members were submitted to stakeholders in April 1995 for feedback. So that everyone works in the same direction, the Tier II workgroups follow the IHDT guiding principles. In addition, each meeting of the IHDT and the Tier II workgroups follow a set of ground rules. These ground rules serve as a guide for conduct by the members and ensure that everyone and their views are respected. The IHDT's ground rules are: start and end meetings on time; meeting agenda changes must be agreed to; full participation by all members; each person is to be listened to and treated with respect; there are no side conversations during the meeting; there are no "cheap shots"; and the meetings are to be documented and follow up on actions is to occur.

Creativity and innovativeness are encouraged at both tier levels. When ideas are proposed, the IHDT reaches a unified opinion about the ideas through consensus. This means that all members of the IHDT arrive at the same opinion by common consent. No idea is pursued if there is one member who can not accept the idea. With work arranged into smaller units, principles applied, and ground rules set, the IHDT started working for Indian people.

1.4.2 The Tier II Workgroups

The detail work is accomplished mostly by the Tier II workgroups. The IHDT appointed workgroups for the following areas: clinical and public health operations; business, administrative services, and budget operations; self-determination and Federal operations; workforce redeployment activities; core IHS Headquarters operations; and information resources infrastructure. The broad areas were submitted to stakeholders in March 1995 for feedback on their appropriateness to the Indian health care system.

The six workgroups met together in March 1995 to get oriented to the entire process and to discuss their charges from the IHDT. Through June 1995, the workgroups worked independently on forming and analyzing options for their areas. At least two IHDT members are appointed to each workgroup to act as liaisons to keep the work occurring at the two levels unified. They fully debate their workgroups' ideas and explain the options and the proposals.

The workgroups analyze ways for making Agency functions to better meet the changing demands on the Indian health care system. They study how to make the functions operate together better so that patient care benefits the most. They match support functions to clinical and public health functions so that Indian communities can be healthier. As ideas were forming, the IHDTmembers review them, debate them, and provide additional guidance to the workgroups. The guidance may have been for the workgroup to study an idea further, to focus its emphasis in a particular direction, or to abandon the idea completely.

1.5 Common Design Themes

As ideas were unfolding and options were developing, the IHDT recognized that common themes were forming for improving the entire Indian health system. The IHDT submitted the common themes to the stakeholders in June 1995 for feedback. After refining the common themes, the IHDT endorsed nine themes to serve as planning assumptions. These themes provide the framework followed by the Tier II workgroups in developing their proposals to the IHDT. The themes are listed below.

1.5.1 The Nine Common Design Themes

1 Delegate essential management and decision making authorities to the local health service delivery site. Redesign accountability requirements appropriate to the decentralized authorities.

The IHDT endorses maximum delegation of management and decision making authorities and responsibilities to the lowest level feasible. A basic idea is to empower local I/T/U programs to act flexibly and expeditiously. The IHDT

charged Tier II workgroups to recommend specific authorities, functions, responsibilities, and resources to delegate from Headquarters and Areas to I/T/Us. The workgroups were asked to identify how accountability for performance will be assured**.**

2 Methods of delivery of health services are decided locally. The local AI/AN community participates in the decision making process.

The IHDT endorses the principle that health service delivery decisions must occur at the local level and involve tribal and community participation. Each I/T/U will decide the appropriate mix of health care services and the appropriate methods or sources consistent with local needs and available resources. The IHDT will not propose restructuring or redesign of local level I/T/U health programs. It will focus on redesigning area, regional, and national support systems.

3 Shift roles of Headquarters, Area Offices, and service units from directing and controlling to supporting the delivery of health services at the local level.

The IHDT seeks a fundamental change in the role of IHS' national and Area support systems. The new focus is on supplying needed support services; not on directing, controlling, and overseeing program operations. The primary justification for national/regional/area functions is to support the health operations of local I/T/Us. The performance for most Headquarters and Area Offices will be measured by how well field health programs are served. The IHDT also charged the Tier II workgroups to identify innovative and simplified ways to assure necessary accountability without interfering with the primary mission to supply support services to the field.

4 Invest selectively in appropriate technologies and processes to: Improve health care delivery, expand options for administrative and professional support and increase efficiency of operations, and provide reliable data on AI/AN health needs, program accountability, costs and managed care.

The IHDT recognizes that selected communications and automation technologies are essential for successful local operations. The IHDT charged a Tier II workgroup to determine what capabilities are needed to provide administrative and professional support services from support centers to a

diverse set of sites often located in remote areas. The key idea is to provide remote I/T/U sites with access to several possible sources of professional and administrative support services. The workgroup offers proposals for demonstrating advanced telemedicine applications in several sites and recommendations for the infrastructure necessary to support a national data bank on AI/AN health needs, costs, and program performance.

5 Streamline Federal administrative processes (i.e. procurement, personnel, budget).

The IHDT finds that simple organizational restructuring will not accomplish all needed improvements in the IHS. With continuation of Federal downsizing and workforce ceilings, the IHS will no longer be able to do the same work with fewer people. In many cases, the internal work processes must be simplified, tasks must be streamlined, and new innovative ways to supply support services to the field must be identified. The Tier II workgroups were charged to offer specific recommendations on how to overhaul work to improve efficiency. The IHDT identified simplification of IHS' budget structure, personnel actions, and acquisition practices as the highest priorities for change.

6 Reconfigure roles, capabilities, and structures of Headquarters and Area Offices to provide health professional and administrative support appropriate to the current and future mix of I/T/Us.

The IHDT finds that the 40-year-old organizational structure of Headquarters and Area Offices is no longer optimum for supporting the diverse and evolving needs of locally managed health care operations. The Tier II workgroups were charged to refine alternative models for configuring Headquarters and Area Office structures and capabilities to better meet the changing mix of Federal, tribal, and urban health programs. The IHDT charged the workgroups to develop recommendations for a more efficient, streamlined Headquarters that focuses on essential core functions related to national scope. Headquarters functions that are now focused on operational policy, oversight, and field support will be shifted to the field. The IHDT also recognizes that roles and capabilities of Area Offices will change.

7 Establish centers to provide administrative and professional support services to I/T/Us in more than one area.

The IHDT finds that the existing Area Office configurations are no longer optimal to support field operations efficiently and effectively. The IHDT recognizes that many Area Offices are unable to maintain the necessary critical mass of expertise and capability in every professional or business function. It recognizes that some pooling of resources and capability is necessary to maintain high quality support services to I/T/Us. The IHDT adopted an approach to allow formation of 'support centers' to provide high quality services to I/T/Us in more than one area. The IHDT has charged the Tier II workgroups to recommend a number of models for support centers including the possibility of new regional centers merged from existing Area Offices and the possibility of existing Area Offices beginning to pool resources and specialize according to strengths. The workgroups were also asked to identify the criteria for choosing among various models and criteria by which I/T/U might be assigned to a support center or, alternatively, how an I/T/U might select or negotiate arrangements with a support center.

8 Develop agreements to collaborate and share resources among agencies to enhance programs for AI/AN communities.

The IHDT finds that the IHS can take advantage of a number of opportunities to collaborate with other agencies and reduce duplication of some functions. Tier II workgroups were charged to identify specific functions and agencies for which mutually beneficial collaboration is possible.

9 Enhanced communication among I/T/Us and stakeholders is essential for implementation of redesign and for successful operating partnerships in the future.

The IHDT continues to emphasize the involvement and participation of stakeholders in the process to design and implement successful partnerships.

1

FINDINGS AND CONCLUSIONS

Before the IHDT considered proposals for a new Indian health system design, it assessed the status of the IHS and conditions affecting its ability to meet the health needs of AI/ANs. It did this in three ways. First, it considered external forces that are pressuring the IHS to change. Second, the IHDT asked customers and IHS employees to submit their views about the system's performance and to suggest improvements. Third, Tier II workgroups assessed the status of various aspects of the existing system in developing proposals for improving the system. The findings and conclusions from these assessments are summarized below.

2.1 External Forces of Change

The IHS operates in a health care environment that has changed dramatically since 1955 when IHS was transferred from the BIA. While the IHS has evolved during the last 40 years, including being elevated to an Agency, it has not fundamentally reshaped its organizational structure and internal business processes. Of all the external forces affecting health services for AI/ANs, the IHDT cites the following reasons as the most compelling to make changes to the IHS overall structure.

2.1.1 Government-to-Government

Providing Federal health services to AI/ANs is based on a special relationship between Indian Tribes and the U.S. The Indian Self-Determination and Education Assistance Act of 1976, as amended, gave new opportunities and responsibilities to the IHS and Tribes in delivering care. This policy emphasizes tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen the Federal treaty obligations even though many Tribes have assumed the role of providing health care for their communities.

President Clinton acknowledged the special government-to-government relationship at the historical meeting with tribal leaders in April 1994. He signed an executive directive that requires every department and agency of the Federal government to remove barriers preventing tribal government consultation before policy decisions are made that affect Indian people.

Conclusion: The IHDT concludes that the IHS organizational structures and operations should be adapted to further facilitate the role of tribes in operating Federal programs and to facilitate government-to-government consultation.

2.1.2 AI/AN Health Conditions and Need

Today, about 1.4 million AI/AN receive health care services from IHS and Tribes. These services are provided to AI/AN's living on 250+ Federal reservations and in other rural and urban areas. This service population is increasing because of natural growth and from additional tribes newly recognized by the Congress. About 700,000 AI/AN do not receive any IHS or tribal health care services. This unserved group resides in states that do not have Federal reservations and in urban areas that have no urban Indian health care programs.

The AI/AN population is economically disadvantaged. They experience higher unemployment and lower socio-economic status. This puts them at risk to adverse health consequences. They experience the effects of complications of poor nutrition, sanitation, and housing found in many Indian communities. According to the 1990 Census, 32 percent of AI/ANs live below the poverty level compared to 13 percent for U.S. All Races. Poverty in all populations is related to both poorer health status and diminished access to health care services. The IHS and Tribes are the primary, often the only, source of health care in many AI/AN communities. Some of these communities are in the most harsh and remote regions of the U.S.

The health status of AI/AN people has improved greatly in the past 40 years. This improvement is due, in part, to IHS programs. Widespread immunization, better sanitation, better access to primary care are reasons for the improvement. In addition, a subsequent decline in communicable diseases has reduced AI/AN mortality. On some health measures, the health status of AI/ANs approaches that of the general population. Such general improvements mask substantial regional differences that still persist. Ironically, some health problems (e.g., heart disease, cancer, and stroke) are now more prominent among AI/ANs because their health status and life expectancy is approaching that of the general population. Moreover, health problems related to alcoholism, accidents, and higher risks related to economic disadvantages and lifestyles continue to plague many Indian communities.

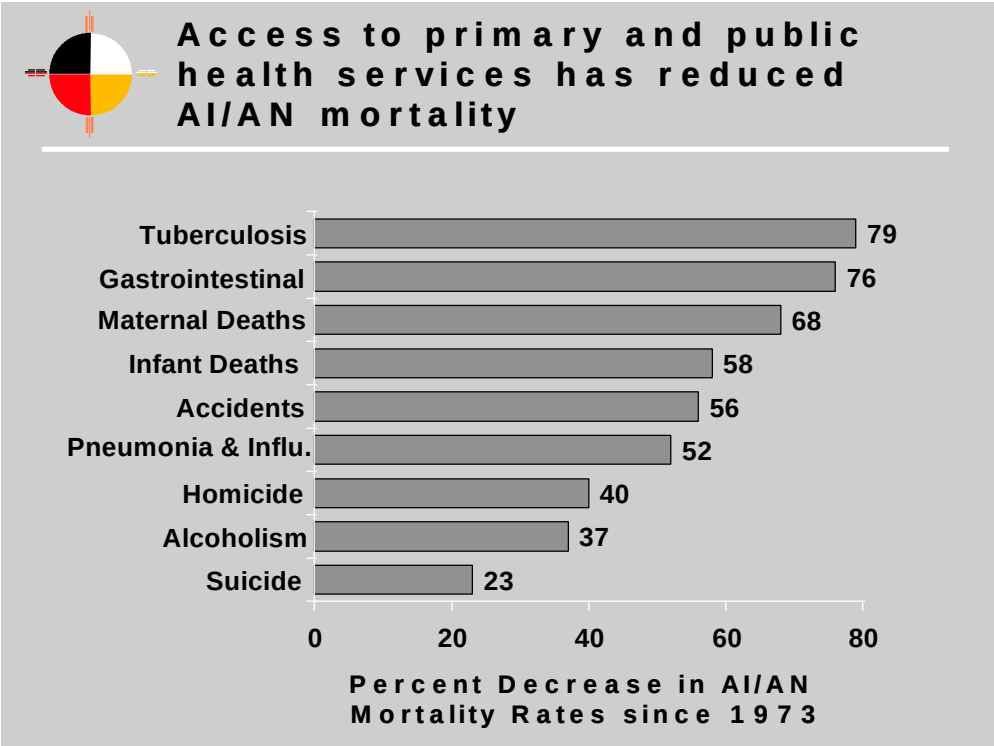

Figure 7

Conclusion: Combining public health services with community oriented primary clinical care are chiefly responsible for gains in AI/AN health status. The IHDT concludes that programs responsible for such gains should be continued, and that no single health care model is appropriate for all of Indian Country. The largeness of Indian Country and the differences from community to community calls for a mix of services best fitting the local needs.

2.1.3 Changing Health Care Industry

The IHS health care model integrates public and personal medical services to a degree not found elsewhere in the health care industry. This is done in places where access to other health care systems is limited. The model is unique in its approach and the I/T/U system is partially separated by geographic isolation from the mainstream health care industry. However, Indian health care remains linked with the health care industry at large - operationally, financially, and professionally. The changes that have and are occurring throughout the health care industry also affect Indian Country. Important changes that have implications for the I/T/Us are:

- Costs of medical care continue to increase faster than the general rate of inflation. In the past, the IHS budget was augmented to compensate for rising costs. Future IHS budgets probably will not include more funds to cover rising costs and some absolute reductions in IHS' budget are possible.

Unless other revenues are increased, from third parties for instance, this will force actions to compensate for lost buying power, including streamlining of both support and front-line health operations, further restrictions on medical priorities, and possible imposition of new restraints on health care services and eligibility.

- Technology and medical practice standards continue to advance. Typically, I/T/U programs focus on primary health care services and constrain the purchase of complex technology intensive services. However, as the AI/AN population grows and ages, the need for more complex and expensive technologies will increase.

- The severe financial strain experienced by small rural hospitals through out the U.S. also acutely affects IHS and tribal hospitals. The IHS and tribal hospitals are smaller than the average rural hospital. They realize fewer economies of scale and experience more infrastructure costs (e.g., housing

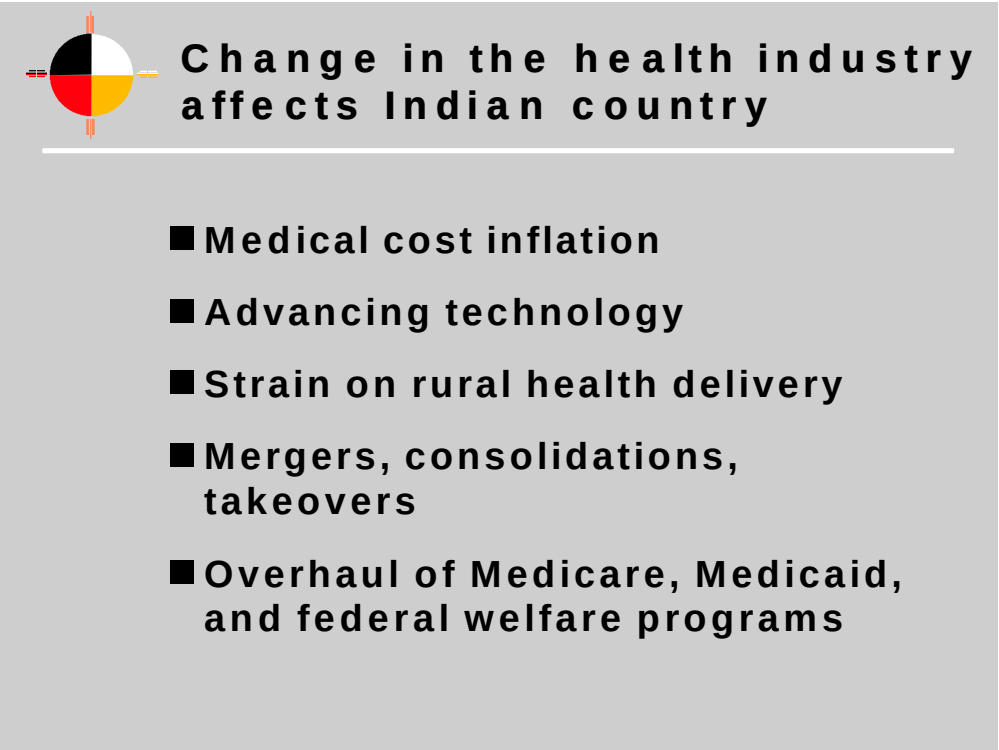

Figure 8

for employees on reservations) that are associated with remote locations and sparsely populated regions. Sustaining full acute inpatient care capabilities in the smallest hospitals is increasingly problematic.

- Mergers, consolidations, and takeovers are increasingly common as the health care industry restructures to accommodate managed care, growing competition, and market shakeouts. The prospects for tribes to takeover IHS hospitals and clinics for successful independent operation runs counter to the industry-wide trend to consolidate smaller independently operated hospitals and clinics into large vertically integrated health care systems.

- Constrained government health care spending, especially in Medicare and Medicaid, will potentially limit and/or decrease third party revenues to IHS and tribal programs. Proposals to convert Federal Medicaid funding to "block grants" to States will also affect how I/T/Us are funded. Possible new caps on payments and more restrictive eligibility requirements could reduce I/T/U revenues. In some cases, AI/ANs who are eligible for Medicare or Medicaid benefits could be assigned to managed care organizations that contract with the state. Such shifts could further diminish the I/T/U user base and erode revenues, economies of scale, and financial stability.

Conclusion: The health care industry is changing and will continue to impact the Indian health care system. Some changes are increased medical care costs, advanced technology, and stricter medical practice standards. The financial strains experienced throughout the U.S. affect the IHS and tribal hospitals and clinics and urban Indian programs. The IHDT concludes that the Indian health care system cannot stand still amid the changes. New ways of doing business should be considered at all levels. One consideration at the local level is to seek affiliations with other I/T/U's, other public agencies, and private sector health care programs, where such affiliations would strengthen local capabilities and stability.

2.1.4 IHS Delivered Programs Shifting to Tribal Contracting and Compacting

The percentage of Federal Indian health care programs transferred to tribes and tribal organizations has continued to grow since the Indian Self-Determination and Education Assistance Act was enacted into law in 1976. About 35 percent of the IHS services budget is now contracted or compacted by Tribes and Tribal organizations under this law. Amendments to the Act also allow transfer of proportionate shares of pooled resources (that amount of shared resources that supported contracted or compacted health programs formerly operated by IHS) from IHS Area Offices and Headquarters.

The amount of contracting and compacting by Tribes varies among Areas. A large percentage of IHS programs has been transferred to tribal control in the Alaska Area, California Area, Portland Area (Washington, Oregon, Idaho), Bemidji Area (Minnesota, Wisconsin, Michigan) and in Oklahoma Area. The

proportionate transfer of resources and responsibilities to Tribes and tribal organizations in these areas has reduced both the remaining responsibilities and capabilities. While the law protects the share of pooled Area Office and Headquarters dollars that remain to support health programs of non-

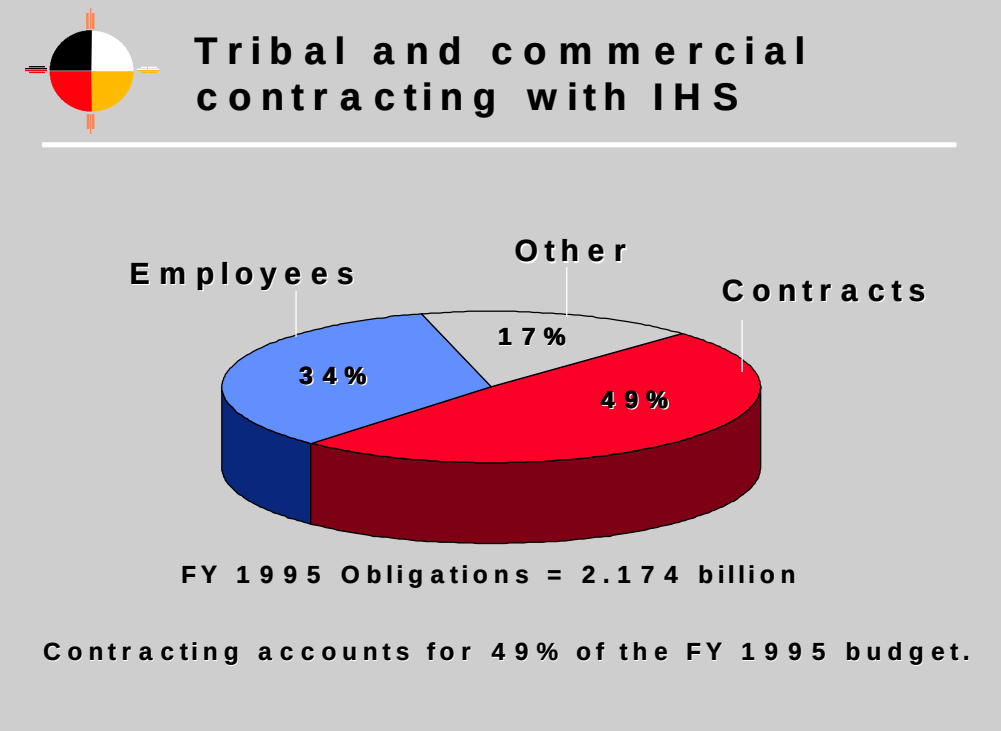

Figure 9

compacting/contracting Tribes, the proportionate downsizing of pooled operations, together with Federal FTE and administrative budget reductions, has resulted in reduced economies of scale in some Area and Headquarters operations. In those Areas with the highest percentage of transfer, the remaining resources may fall below a minimum critical mass necessary to sustain a fully functional support system. All these factors taken together have resulted in some gaps in some Area and Headquarters functions. As one Tier II workgroup noted, these gaps have resulted in a diminished capability that sometimes more resembles “swiss cheese” than a seamless support system.

Conclusion: Dividing and proportionate downsizing of pooled Area and Headquarters operations is necessary to support Self-Determination contracting and compacting. Remaining administrative and program support system capabilities must be rearranged to reflect diminished responsibilities to contracts and compacts and consolidated to maintain the critical support capabiliities necessary for IHS health programs that are not transfered to tribes.

2.1.5 Federal Workforce Downsizing

President Clinton proposed changes to Federal agencies and departments that would allow a 12 percent reduction of the Federal workforce over a period of 5 years. The targeted reduction was later raised to a total 272,000 FTE employees by the Congress. The Congress also removed a previous exemption for the IHS from FTE ceilings. This means that the IHS will share in the overall downsizing of the Federal workforce.

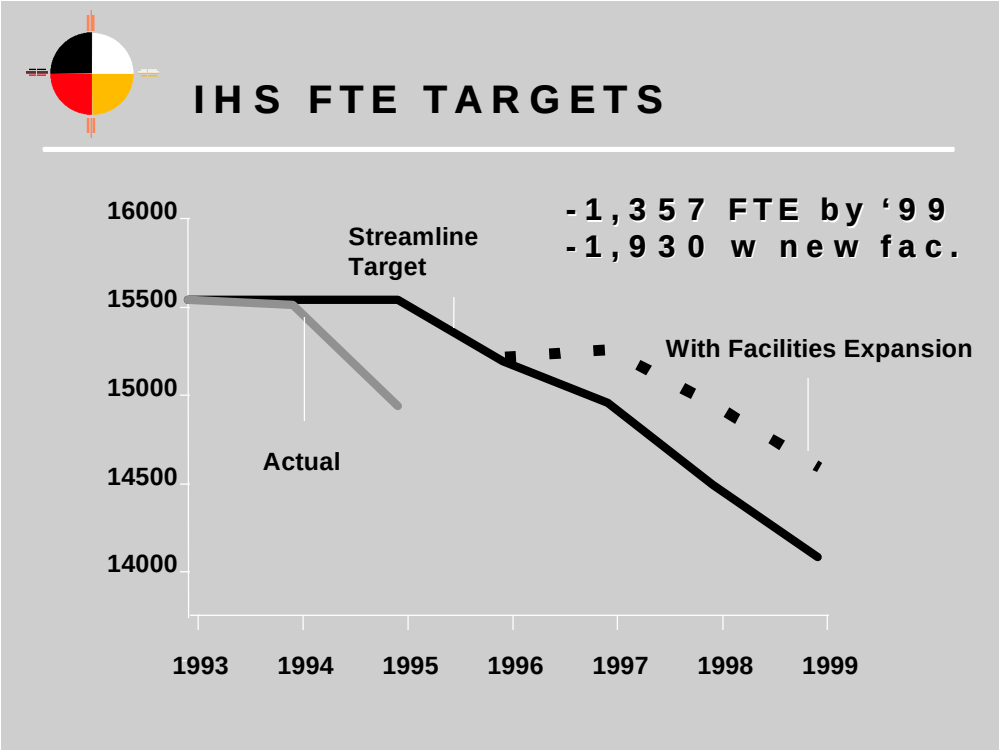

Figure 10

The Federal workforce in the IHS must be reduced from about 15,000 FTEs to 14,000 FTEs by 1998, a reduction of 1,000 FTEs to meet the Agency's targeted share of FTE reductions. The IHS policy is to absorb the target reductions above the service unit level to the maximum extent practical. The IHS instituted a general freeze on hiring at Area Offices and Headquarters in 1994. Hiring related to critical health care functions at service units was not frozen, however, the inability to backfill non-clinical positions also impacts local health care services. Since 1993, the total number of FTEs employed above the service unit level has declined by about 851 FTEs. Meanwhile the number of FTE employees at service units has risen by about 350 FTEs. Already, the FTE reductions at Headquarters and Areas have begun to tax capabilities and

services. These effects will become even more severe as the FTE reductions accumulate further.

Conclusion: The IHDT concludes that gaps in the IHS Federal workforce will continue to grow at random. Unless action is taken to consolidate staff and coordinate remaining functions as part of planned strategy, these gaps will become critical.

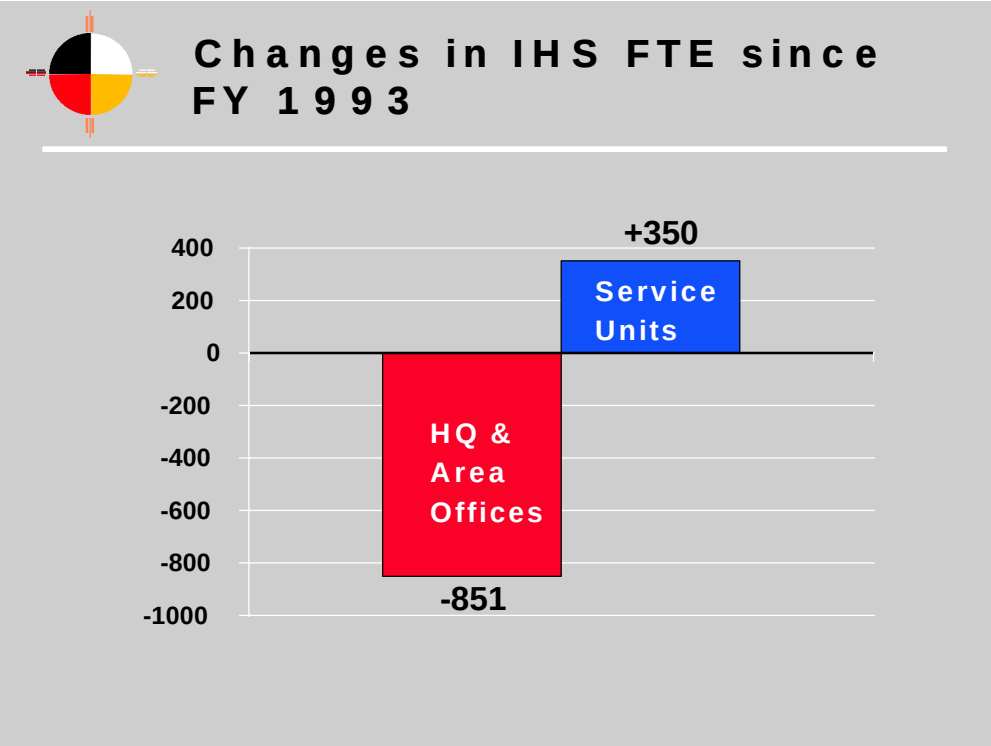

Figure 11

2.1.6 Reinventing Government Initiatives

The Administration's Reinventing Government (REGO) initiatives propose to change the way government operates---to shift from top-down bureaucracy to entrepreneurial government that empowers citizens and communities to change the government from the bottom up. It seeks to minimize over control, redtape, and micromanagement that bind and stifle creativity and productivity. Equally important, it seeks to place customers first by creating incentives for the government to serve their needs.

Many of these goals are consistent with community and tribal empowerment so long sought by AI/AN people. However, the Tribal leaders serving on the IHDT had several significant reservations.

- *"Sovereign nations can not be dealt with identically under a single policy and*

must be consulted separately through a government-to-government relationship."

- *"It is not the lack of legislative authorizations or knowledge about delivering health care that is the problem. Congress has authorized the best health care system in the world for Indian people. The problem is that the authorized system is not funded."*

- *"There is a distinction between the purposes of the National Performance Review to streamline and improve the Federal government versus the need to maintain and improve the capabilities of Tribal governments and services to Indian people. The purpose of the IHDT is to redesign the IHS with full tribal participation to more effectively use limited IHS resources. As a expression of sovereign relations with Indian Nations, Indian leaders participating in the redesign of the IHS seek a commitment to retain and redeploy all resources gained from either reinventing government or IHDT restructuring and to reinvest such resources in patient care services to Indian people."*

As part of this initiative, the HHS is also redefining its mission. Structural changes are occurring after the departure of the Social Security Administration (SSA) from the HHS. This reduced the HHS budget by 50 percent. In view of this major change, the Office of Assistant Secretary for Health was eliminated as a layer with line authority over the IHS. The Assistant Secretary was converted to a staff position in the Office of the Secretary and the IHS reports directly to the Secretary. The Department also has entered into discussions with the BIA about how IHS and BIA can work more effectively together at the Area and community levels. This is a first step toward creating "one stop shopping," to enhance service delivery while reducing each department's administrative overhead.

Conclusion: The IHDT generally endorses the goals of the REGO but with an important distinction. That distinction is to maintain and improve the capabilities of Tribal governments and to reinvest all resources gained from IHS restructuring into patient and community services to Indian people.

2.1.7 Congressional Directive to Consider Consolidation

The Congress has directed the IHS to submit a plan to restructure as part of its budget request. This directive is contained in the House of Representatives Report 103-551, June 17, 1994, page 107. See Figure 12. Since that Report, the November 1994 elections have created new leadership in Congress that is even more committed to public sentiment about downsizing the government.

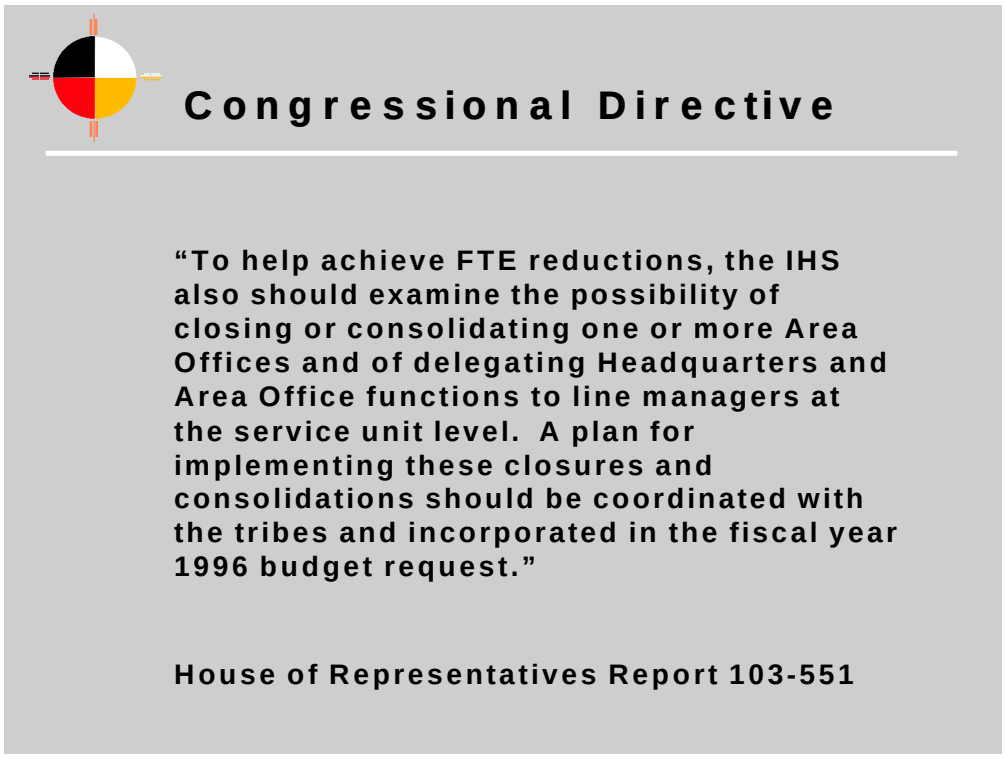

Figure 12

Conclusion: The IHDT concludes that both political parties in the Congress agree that the IHS should restructure and streamline.

2.2 Patients/Employees Speak Out About Change

The patients and IHS employees suggest reducing and reconfiguring the bureaucracy, and placing emphasis on local I/T/U field operations, and on increasing patient care services. In general, these suggestions were the most prevalent themes conveyed by persons responding to the Employees/Customer Suggestions Survey when asked how they would change the system.

The survey was initiated to provide a way for stakeholders in Indian health to participate in designing a new IHS. Over 1,000 responses have been received. The preliminary data results were shared with the IHDT at its February 1995 meeting. The data was categorized by issue and provided to Tier II work groups.

The survey was voluntary and, therefore, is not representative of all Indian people or Indian country. The IHDT believes that the results provide useful information and identified consistency in themes from patients and employees.

2.2.1 Patients and Employees Survey

The IHS employees made up about 50 percent of the survey respondents. Most of these employees are in professional/highly skilled job categories and high educational categories. Nurses, physicians, dentists, administrators/managers, and engineers made up 45 percent of all respondents. Most of these respondents work in service units and reflects the largest job pool of IHS employees. Only 10 percent of responses came from tribally operated service units, urban Indian programs, or other locations.

Approximately 50 percent of the respondents obtain some health care at an IHS service unit. Approximately 40 percent indicate they obtain health care from sources other than the IHS system. About 10 percent of the survey respondents obtain care from Tribal or urban systems.

2.2.2 What Customers Want

Two-thirds of those responding want service when its needed and without waiting. They want quality care provided by helpful, caring, and respectful staff. Remarks about "long waits" and "lack of appointments" implied widespread concern and frustration with not getting health care services when needed. Other items that were mentioned frequently are the desire for a benefits package equivalent to what other Americans get and access to services in the local community.

2.2.3 What is Working Well

Respondents (25 percent) think the existing health care system works well in areas like immunization; quality care; prevention; maternal and child care; and community oriented primary care. Many responses reflected variety that may be explained by the diversity of respondents and their experiences in the system and by the diversity of the system itself from location to location.

About 83 percent of respondents said they were either very satisfied or moderately satisfied with the services available to them through an I/T/U. About 17 percent were either moderately unsatisfied or very unsatisfied with the services available to them. Customers responded with similar frequencies to a question about how they are personally treated at the local I/T/U.

2.2.4 What to Change

The most frequently reported suggestions were to reduce waiting times, get highly trained providers (or set higher standards), improve outdated facilities,

offer more specialized/advanced services, and move health professionals from administrative positions to patient care duties.

When asked what should be eliminated, the most frequent suggestions were unnecessary regulations, red tape, paperwork, duplicate layers, and middle management. Many employees also suggested streamlining and consolidating IHS Headquarters and Area Offices and offering pay scales comparable to those found in the health care industry.

Procurement and personnel functions were the two most common responses to what the Agency could do better, faster, and cheaper. The three most frequent ways that respondents suggest work be improved are to reduce red tape, unnecessary rules and paperwork, simplify the work process, and hold employees accountable for their performance or lack of performance.

2.2.5 Views about Local I/T/Us

Most respondents suggest augmenting or expanding local I/T/U clinical care and community programs, and that I/T/U administrative functions be reduced or streamlined. Respondents wanted to protect local I/T/U programs, however, about 20 percent recognized that affiliations with other I/T/Us or outside networks may be necessary to obtain comprehensive services.

2.2.6 Views about Area Offices

Most respondents suggest reducing and streamlining Area Office program, professional, and administrative functions, and transferring some functions to field locations, and consolidating other functions into regional sites. These suggestions appear to reflect a general view that the existing structural form and geographic distribution of Area Offices is poorly adapted to meet the support needs of local I/T/Us.

2.2.7 Views about Headquarters

Most respondents suggest reducing or streamlining Headquarters program and administrative oversight functions. Other frequent suggestions are to consolidate all support functions into regional sites, transfer some functions to field locations, and eliminate unnecessary layers.

2.3 Structural Models Illustrated

The Tier II workgroups proposed various structural models for consolidating support functions now performed at IHS Headquarters East, Headquarters West,

and at Area Offices. The existing structure and the two primary alternatives are illustrated and explained below.

2.3.1 Existing IHS Organization

The existing IHS organizational structure consists of 3 levels - Headquarters, Area Offices, and local I/T/Us. Headquarters' functions are located in several places, but primarily in Rockville, Maryland, and at Headquarters West in

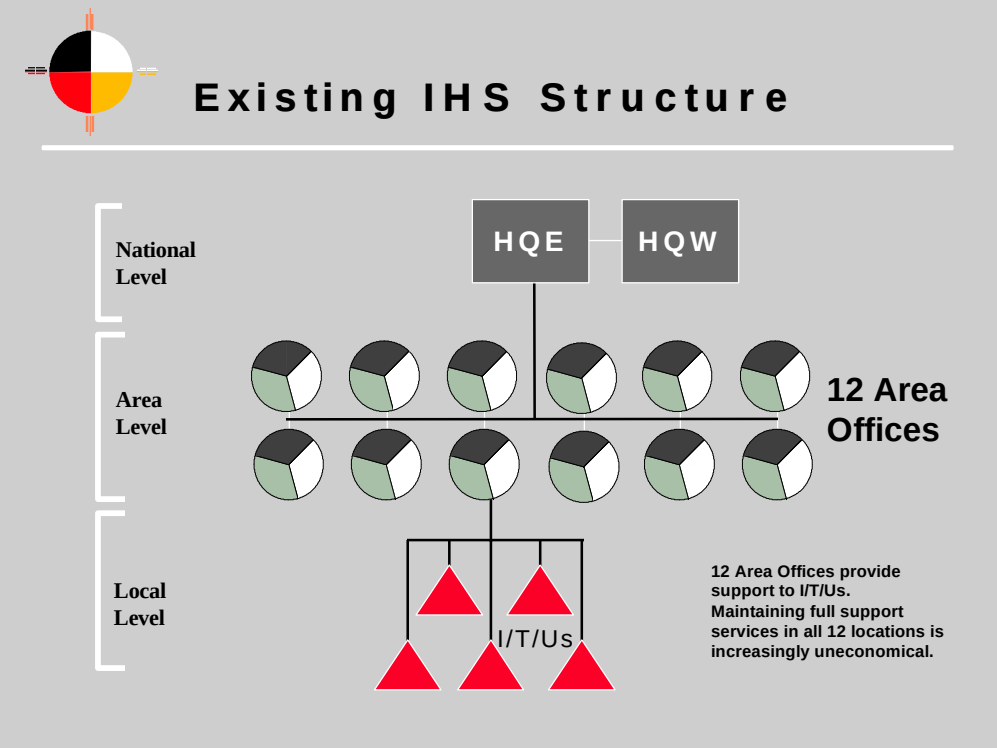

Figure 13

Albuquerque, New Mexico. Twelve Area Offices perform various administrative and program support and oversight roles. The Area Offices are: 1) Aberdeen Area - Aberdeen, South Dakota; 2) Alaska Area - Anchorage, Alaska; 3) Albuquerque Area - Albuquerque, New Mexico; 4) Bemidji Area - Bemidji, Minnesota; 5) Billings Area - Billings, Montana; 6) California Area - Sacramento, California; 7) Nashville Area - Nashville, Tennessee; 8) Navajo Area - Window Rock, Arizona; 9) Oklahoma Area - Oklahoma City, Oklahoma; 10) Phoenix Area - Phoenix, Arizona; 11) Portland Area - Portland, Oregon; and 12) Tucson Area - Tucson, Arizona. Each of the Area Offices serves a set of local service units. Service units are operated directly by the IHS with Federal employees or by a
Tribe or Tribal organization under a Self-Determination contract. Urban Indian health programs are generally independently chartered organizations that receive some funding from IHS, but relatively little administrative or

programmatic support services.

2.3.2 Area Office Support Functions: Authorized and Actual

Most Area Offices are authorized for a full complement of functions necessary to supply essential professional and business support services to multiple local service units. Most local service units are too small to justify and pay individually for a full complement of administrative and program support services on-site. Area Offices were originally formed to pool a limited amount of resources from service units and to use those resources to supply support services (e.g., personnel, finance, etc.) that each could not afford to perform individually.

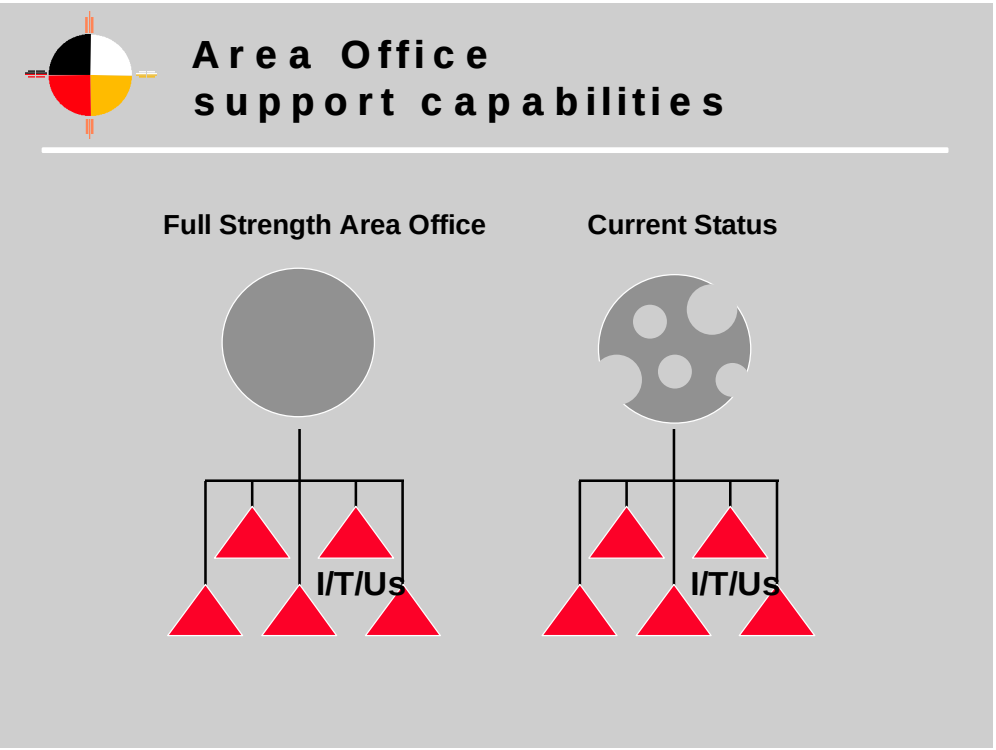

Figure 14

Figure 14 illustrates support functions that are performed for multiple services units when Area Offices are at full authorized strength. However, as described previously, many Area Offices (and Headquarters also) have experienced downsizing, budget reductions, transfers of proportional shares of resources to Self-Determination compacts/contracts, and other staff losses from hiring freezes and Federal employee "buy-outs." In some cases, the resulting Area Office capacity more nearly resembles the "swiss cheese" figure on the right than a seamless support system on the left in Figure 14. In many cases, the quality and timeliness of essential services are greatly affected.

While Area Offices can restructure internally to compensate for limited downsizing, those Area and Headquarters Offices that experience more substantial losses can not solve the problem solely by internal restructuring. In some cases the remaining staff may be a poor match for the remaining work or may be insufficient to cover all the bases. In such cases, looking beyond the Area boundaries is necessary to pool remaining resources for restoring support system capabilities.

The Tier II workgroups proposed a variety of structural models for consolidating functions among Areas and Headquarters. See options proposed by Tier II workgroups in Section 7.1. While proposals were discussed to privatize particular support services and to consider some consolidation of selected functions with the BIA, the main proposals are various models for internal consolidation. Most models assumed a continuing presence for an Area Tribal liaison role regardless of where other support functions were consolidated. The IHDT used the term "RSC" to refer to:

- consolidated functions under both Models A and B,
- emphasize that I/T/Us beyond the existing Area boundaries would be served from the centers, and
- emphasize the new role of support for I/T/Us rather than control.

2.3.3 Model A: Traditional Geographic Consolidation

Under the traditional approach to consolidation, operating sites that are no longer economically feasible are closed. Their resources and responsibilities are consolidated into fewer and stronger sites. This is often accomplished by consolidating several smaller operations into one larger regional operation - hence the term geographic consolidation. The composition of the newly consolidated operation is mostly unchanged. It performs the similar functions as before but on a more economical scale for a larger customer base.

Using this approach, the IHS would consolidate many functions and resources from existing Area and Headquarters Offices into several RSC. The RSC would use the consolidated resources to expand capabilities to serve I/T/Us over a broader geographic range.

Advantages:

- All models would use additional resources deployed from a downsized Headquarters to enhance field support activities.
- The model would achieve consolidation and pooling of resources for a critical mass of funds, staff, and expertise for cost effective support operations.
- Model A would provide "one stop shopping" for a full complement of support

services together in one place. Co-location of functions also provides space, communication, and cost benefits.

- Lines of authority and accountability would be clear.
- IHS and tribes are familiar with this model.

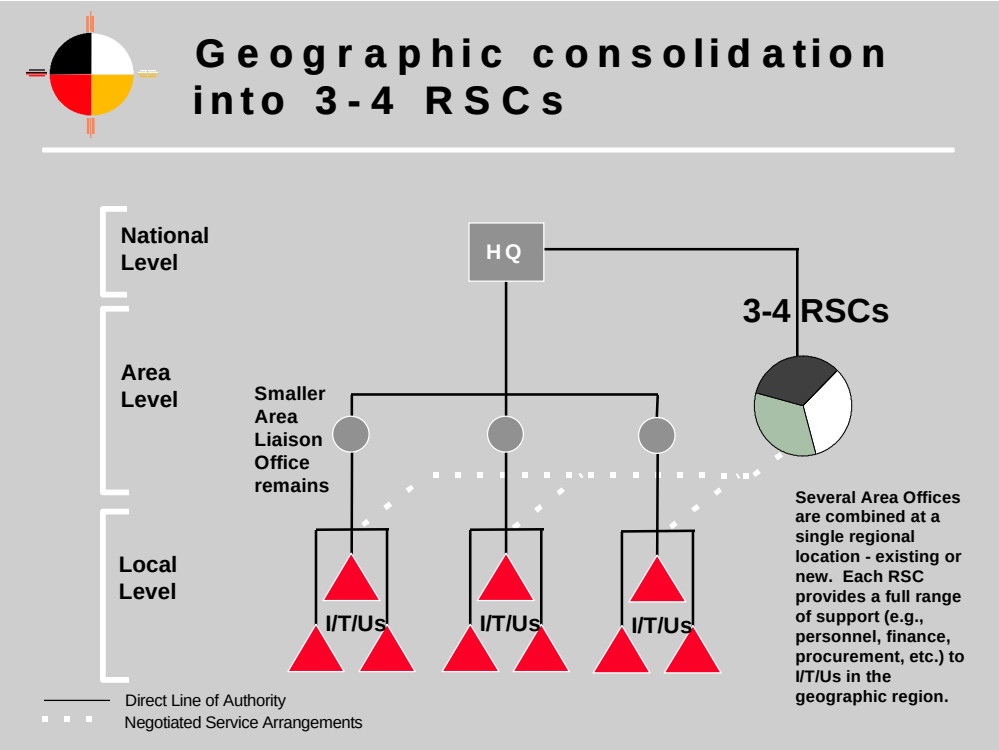

Figure 15

Disadvantages:

- Under this approach, most functions and staff from Area Offices would be consolidated elsewhere.
- A small office would remain as the Area tribal liaison office to perform Office of Tribal Activity functions.
- There would be potential for political reaction about which Area Offices to consolidate and downsize and the location of the new RSC.
- I/T/Us would probably have limited or no choice in selecting the RSC to serve them, at least initially.

2.3.4 Model B: Functional Consolidation "Specialized Centers of Excellence"

The Tier II workgroups also proposed a model of consolidation that is not based on geographic Area Offices. Model B consolidates individual functions, not whole offices, into fewer sites that are more economically feasible. Existing Area

Offices could specialize in a given support function (e.g., personnel, finance, etc.) and would downsize in all other functions except the Area tribal liaison role. Each specialty site would not provide the full complement of all support functions to the I/T/Us that it serves. The staff and resources providing other than the specialty functions would be transferred to other specialty sites.

Advantages:

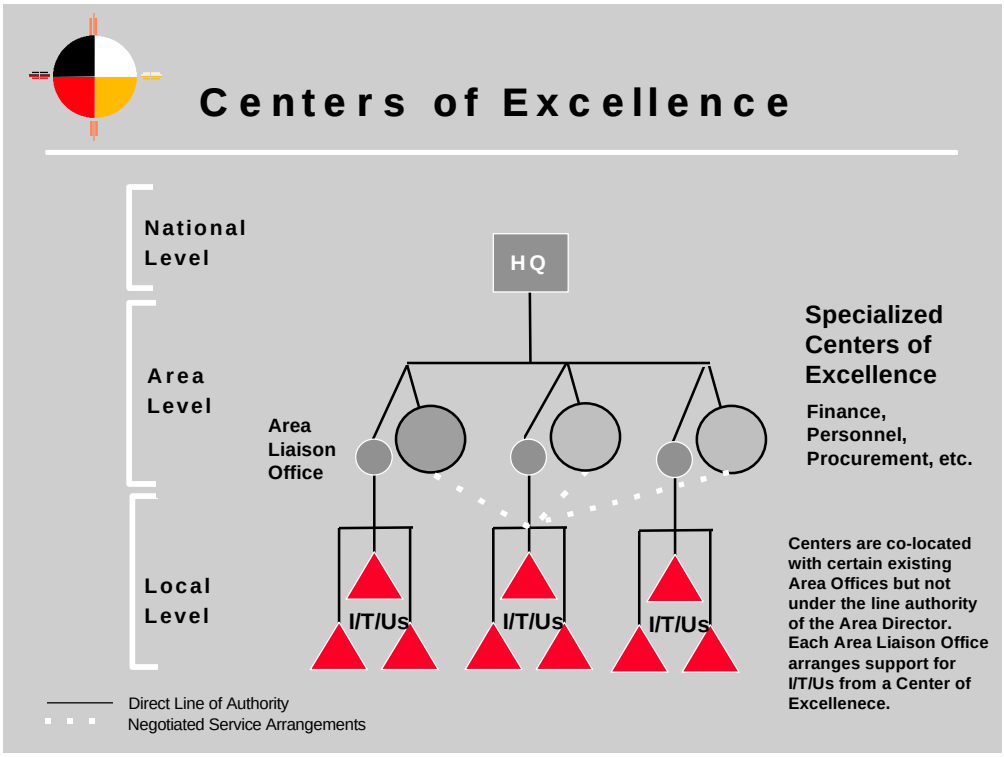

Figure 16

- Model B would use additional resources redeployed from a downsized Headquarters to enhance field support functions.
- This approach would achieve consolidation and pooling of resources by individual function.
- Model B would allow existing Area Offices to continue, however, each would be downsized from current levels and would specialize in a support function.
- This approach would build on existing Area Office strengths.

Disadvantages:

- Model B would be a new configuration for which IHS and tribes have little experience.
- I/T/Us would deal with multiple support center locations. No single authority would be accountable to the I/T/U.

- The lines of authority and accountability are unclear. Multiple sources increase the risk of something falling through the cracks for which no one takes responsibility.
- Multiple sites and multiple sources of support services would require excellent telecommunications from the I/T/Uss to each specialty office.
- While some Area Offices have high potential as a center of excellence, many are currently unable to expand their services more widely because of resources shortages.
- The potential for confusion during the transition phase would be higher.

2.3.5 Mixed Approaches

The IHDT recognizes that the implementation team may consider a mix of Models A and B. The IHDT recognizes that a number of mixed approaches are possible, including consolidating administrative functions into an RSC while maintaining a flexible clinical and professional technical assistance capability in each existing Area Office.

2.4 Proposed Decision Making Criteria

The IHDT proposes criteria to guide consolidation into RSC. The IHDT did not have sufficient time during its brief charter to assess technical factors that must be considered in detailed planning of a reconfigured support system. It did propose some objective criteria to be used in making these difficult decisions. These criteria are listed in Sections 4.2.4 and 4.2.5.

A fundamental concern about consolidation into RSC is the accounting and tracking of resources from an Area Office to the RSC. This concern arises from the need to enable informed Self-Determination/Self-Governance decisions by tribes. The IHDT concluded that while such accounting would be difficult, it is feasible and should not pose a barrier to the RSC concept.

2

RECOMMENDATIONS

The primary design strategies are:

- to restructure only those IHS organizational levels above the local I/T/Us and leave the choice to restructure to the local I/T/Us;
- to change the IHS levels above the local I/T/Us from controlling and directing to supporting the unique needs of the local I/T/Us;
- to pool and consolidate IHS Area Offices and Headquarters resources and expertise to support the local I/T/Us; and
- to invest resources gained as a result of Federal streamlining into patient and community services at the I/T/Us level.

To support these design strategies, the IHDT makes recommendations to create a new Indian health system for the future. The recommendations are not in response to any single issue. The recommendations are specific to empowerment, performance, structural changes, and transitioning to the new system.

3.1.1 To empower the local I/T/Us, the IHDT recommends:

1.1 Delegate appropriate Headquarters and Area Offices management and program authorities to local I/T/Uss for greater decision making authority, control of operations, and accountability for local performance so that the I/T/U can assume greater responsibilities if it chooses.

Resources and staff at Headquarters and Area Offices that are tied to

authorities delegated to I/T/Us should be transferred to I/T/Us in a fair and proportional manner as they become available. Budget, personnel, purchasing, program, and service delivery functions should be performed at the local I/T/U to the extent practical and economical.

1.2 Authorize, upon request, flexibility to the local I/T/U in managing its budget by:

- reducing and simplifying IHS budget line items, and/or
- providing local I/T/U budget reprogramming authority up to 100 percent of any line item account.

Title III tribal compacts have 100 percent reprogramming authority by statute. However, both of the above measures require approval of Congressional committees.

1.3 Authorize I/T/Us to establish "Health Partnership Boards" (suggested title) with membership from the local AI/AN community to participate with I/T/U management in making health care policy.

1.4 Measure I/T/U performance by a few key indicators rather than by extensive monitoring and reviews of internal processes. Recommended key indicators are:

- outputs (personal and public health care services),
- outcomes (as identified in Healthy People 2000 objectives),
- quality standards, and
- fiduciary standards.

Outputs *are services to patients and the community.* ***Outcomes*** *are related to meeting community needs and improving health of AI/ANs.* ***Quality*** *standards may include licensing and credentialing of staff or the institution.* ***Fiduciary*** *standards refer to accountability through industry standard audits, similar to the "single agency audits" of Self-Determination contracts. The local AI/AN customers should participate in the performance assessment.*

1.5 Standardize, streamline, and reduce I/T/U reporting to a minimum core necessary for performance measurement, program and financial accountability, documentation of Indian health care needs, and supporting the annual IHS budget request.

Unless an activity adds value to the program, it should be eliminated. Core information that is essential for one of the above purposes should be reported in the most simple and economical way possible.

1.6 Authorize I/T/Us to enter into sharing agreements and affiliations with other I/T/Us, agencies, and private health care organizations.

It is becoming difficult for some I/T/Us to maintain comprehensive health services economically. Some may need to enter into sharing agreements and other affiliations to strengthen operations and capability.

1.7 Assess alternative sources for I/T/U's essential professional and business support functions. For the most economical and effective way for using resources to meet unique needs, each I/T/U should adjust its own mix of

- local direct hire employees,
- arrangements with Area Office and/or regional support centers (RSC),
- affiliations with other agencies (BIA, HUD, etc.), and
- contracts with Tribes, Indian owned firms, and commercial firms.

Each I/T/U should determine the mix of ways to best meet local needs based on local alternative sources, availability of resources, costs of each approach, quality, and value of the service. Increased costs and FTE reductions may require many I/T/Us to consider changing sources of support services.

1.8 Authorize the I/T/Us to invest in a shared technology and tele-communication network to access a broader array of essential and expanded business and professional support sources than are available and affordable locally.

This capability is essential for the continuation of many rural health care sites, whether IHS, Tribal, or private sector. Sources of necessary support services may be available locally but may not be affordable. A shared infrastructure will allow even small and rural I/T/Us to distribute work, share expertise and capabilities, and sustain operations at a higher level. All I/T/Us will be able to access better, more economical, and more variety in support services by participating in a shared network. A key change is for I/T/U managers to recognize that such capabilities are a routine cost of operations. I/T/Us should explore shared support of "community information systems" and networks with Tribes, the BIA, and other organizations active in Indian communities. Advanced capabilities

that are not affordable individually become possible when shared through cooperative efforts.

1.9 Authorize the I/T/Us to purchase or develop, if not available, billing and accounts receivable systems that are equal to those in the private sector.

This capability is critical for increasing third party revenue for I/T/Us. Third party revenue is vital to the financial stability of most I/T/Us. As a result of State and Federal health financing reforms and growing market forces, the ability to generate revenues from third party sources will become more important. I/T/Us increasingly compete with other health care organizations both directly and indirectly to serve AI/AN patients. Automated billing systems equivalent to those in the private sector are essential.

1.10 Authorize the I/T/Us to develop a few demonstration sites to test the feasibility and cost effectiveness of tele-medicine applications for I/T/Us.

Electronic mail, computer based patient records, electronic commerce, and "smart cards" for patient care should be tested. While the IHDT members believe that tele-medicine is not yet feasible for all I/T/Us, they recognize that tele-medicine and the shared network described in recommendation 1.8 are worth testing.

1.11 Authorize Urban Indian Health Programs to access and participate in support services from Area Offices and/or RSC.

1.12 Revise the personnel compensation rules to reward clinical expertise equal in value to management and supervisory skills.

Financial reward systems should encourage health care professionals to continue in clinical and patient service tracks rather than leaving for a management track to improve pay and advance their career. More flexible salary tracks are necessary for I/T/Us to recruit and retain high quality professionals. Reforms should be pursued vigorously at all levels to simplify and provide greater flexibility in managing and compensating the work force.

3.1.2 For New Ways for Area Levels to Perform, the IHDT recommends the following:

2.1 Formally charter the proposed RSC with the primary mission to support the needs and supply services to local I/T/Us.

The historical reason for the existence of Area Offices - or any pooled function in the IHS - is to perform functions and supply services to I/T/Us that otherwise are not feasible or economical at the local level. The tendency to control, direct, and micro manage is an unfortunate legacy of any hierarchial organization. The I/T/Us are to be empowered with greater flexibility, authority, and autonomy. Consequently, pooled support operations must economically serve the needs of each I/T/U or lose the "business" as I/T/Us find better support elsewhere. Organizations supplying services under this arrangement would naturally seek to become "customer oriented."

2.2 After a period of transition, finance RSCs primarily by service fees negotiated with I/T/Us.

Over a transition period, an I/T/U would be granted control over its budget. This control includes those portions of resources used at RSC for supplying support services to the I/T/U. The I/T/U service arrangements and the fees would be negotiated with the support center on a staggered schedule every 2 to 3 years. One way for I/T/U fees to be negotiated is by units of work provided by the RSC. The fees may be negotiated by the I/T/U or by the Area Director acting as an agent for the I/T/U.

2.3 Streamline, simplify, or eliminate internal rules, paperwork, and work processes if the activity does not add value to the support mission.

Downsized Area Offices and/or RSC will no longer be able to perform the same amount of work in the same way. On average, fewer staff will support more I/T/Us. Support systems and staff at all levels - Headquarters, Area Offices, RSC - must become more efficient. Consequently, internal work must be streamlined. The IHDT recommends actions such as consolidating functions, delegating authorities to I/T/Us for local decision, simplifying and eliminating work processes. Automation and technology are ways to reduce manual work steps and decrease work time. The IHDT suggests reducing mandated work steps performed in Area Offices or RSC by 50 percent in 3 years.

2.4 Establish a "support center board" for each RSC composed of representatives from affected I/T/Us and tribes to promote participation and consultation and to advise or participate in governance depending on the charter.

A board of customer representatives should be an integral role in overseeing the operations of support centers. The boards will assist the transformation to a culture of customer centered service and support.

2.5 Maintain a clinical and public health support infrastructure at the regional level for direct IHS programs and for I/T/Us that choose to use the services.

The local and regional IHS public health infrastructure is an essential foundation for improving health of Indian people. The IHDT endorses maintaining a clinical and public health support infrastructure that is reorganized to better meet today's challenges. Another reason to maintain this continuity is assist I/T/U health care providers in transitioning to delivering care within a public health model. Many I/T/U providers are recent medical school graduates and are trained in delivering care within the medical model.

2.6 Reorganize staff at Area Offices and/or RSCs into cross-disciplinary teams.

Having expertise available at a Area Office and/or RSC does not necessarily require a discipline specific organizational divisions for each professional category (e.g., MDs, RNs, Dentists, Pharmcists, etc.). As the organization downsizes and combines divisions, the staff mix should streamline and generalize in a comparable way.

2.7 Charter the RSC as an independent service organization outside the typical chain of command. As a service organization that supplies support to I/T/Us, the RSCs should operate on a level equivalent to Area Offices but not as an additional layer that oversees and controls Area Offices or I/T/Us.

The IHDT envisions the RSC as a way to provide support services to I/T/Us that the I/T/U or the Area Office can not provide economically. RSCs are to focus on customer support; not on control. To ensure this focus, the RSC will be chartered outside the typical chain of command of Director to Area Director to service unit director. The intent is to shield the RSC from being controlled or influenced by one Area Director. Placing its charter outside the chain of command also prevents the RSC from becoming another level of control between Areas and Headquarters and between Areas and I/T/Us. See Figures 26 and 27 for diagrams of how this could work.

2.8 Build "Entrepreneurial" incentives into Area Office and/or RSC policies, governance structure, and performance standards.

The IHDT believes Area Offices and/or RSC should incorporate incentives to satisfy I/T/U customers and to seek new customers where practical. If some support centers generate business outside of the Indian health system, there is the possibility of improving revenues that would ultimately help expand health care services to AI/ANs.

3.1.3 For New Ways for Headquarters to Perform, the IHDT recommends the following:

3.1 Delegate management responsibilities and authorities related to field operations to Area Offices and/or RSC.

Delegation of authorities and responsibilities from Headquarters is consistent with IHDT strategy to place authorities closer to the customer.

3.2 Redeploy Headquarters staff and dollars that support field operations to Area Offices, RSCs, and local I/T/Us.

The resources that were formerly used by Headquarters to carry out functions that are transferred to the field must accompany the transfer to provide the means to carry out the transferred function.

3.3 Redefine the Director's role (and by extension, the role of Headquarters) as a leader and advocate rather than as an operational manager.

This strengthens the leadership function and frees the Director from routine operational management duties that undermine leadership effectiveness.

3.4 Establish a new Headquarters purpose that shall focus on leadership, service, and support to the local I/T/U rather than on controlling and directing field operations. Headquarters functions should include elements such as:

- Advocacy for AI/AN health and Tribes,
- Leadership in public health,
- Building consensus on priorities,
- Working partnership with Tribes and AI/AN communities,
- Facilitating empowerment for the local I/T/U,
- Unified voice for the I/T/U system,
- Documentation of AI/AN health needs,
- System performance assessment, and
- Indian health data bank.

3.1.4 For Structural Changes at the Local I/T/Us, the IHDT recommends:

4.1 The IHDT decided not to recommend consolidation of I/T/Us or other structural changes at the local level. While some structural changes may be necessary and beneficial, the IHDT strongly believes that such changes are best decided at the local level.

The IHDT focused on restructuring the Area and Headquarters levels as a support system for the local I/T/Us. The IHDT believes that differing local circumstances affect both the feasibility and advisability of local restructuring. The IHDT made several recommendations that delegate additional authorities that empower the local I/T/U to reorganize itself or in conjunction with other I/T/Us. Local I/T/Us require flexibility in responding to the unique needs, conditions, and resources available in local communities. The IHDT could not prescribe a set of restructuring recommendations that are appropriate for all local I/T/Us.

3.1.5 For Structural Changes at Area/Regional Levels, the IHDT recommends:

The IHDT did not reach consensus on a single model for restructuring the IHS. The IHDT recommends consulting further with all tribes on this matter.

5.1.a Consolidate administrative functions, now rendered in 12 Area Offices and by Headquarters, into 3 or 4 administrative RSC sites. The IHDT did not determine the exact number or location of the administrative RSCs. The Phase II restructuring implementation team shall determine the best technical solution for consolidation using the proposed consolidation criteria (see Sections 4.2.4 and 4.2.5). The IHDT will monitor this closely.

The IHDT concluded that budget reductions, FTE downsizing, and gradual transfer of resources and functions from Area Offices and Headquarters to tribes have resulted in a need to rearrange the support system above the I/T/U level. In some cases, the staff and resources have fallen below levels necessary to sustain support services. While internal restructuring by Area Offices is underway, the IHDT believes that simple downsizing of the Area Offices will not eliminate gaps in support functions. The IHDT concluded that pooling of resources above the I/T/U level is essential to reestablish a fully functioning support system.

5.1.b Health professions support and consultation functions, now rendered in 12 Area Offices and by Headquarters, shall be

a) consolidated into 3 or 4 RSC sites, and/or
b) transferred to I/T/U sites with duties to share professional expertise with other I/T/Us, and/or
c) reorganized at larger Area Offices into a multi-disciplinary health team, uniquely tailored to I/T/Us served.

The Phase II restructuring implementation team shall determine the best technical solution for consolidation using the proposed consolidation criteria (see Sections 4.2.4 and 4.2.5). The IHDT will monitor this closely.

A general concern about program support technical assistance located at proposed RSCs is that knowledge would be compromised about unique tribal health needs. This concern is cited regarding the location of RSCs if staff were obligated to support too many I/T/Us over too broad a geographic region.

5.2.a Co-locate administrative functions together in a unified administrative RSC as practical. The IHDT did not exclude functional consolidation into separate administrative centers of excellence, but does acknowledge benefits of co-location (e.g., one-stop shopping concept).

Some IHDT members believe that there are benefits of "one stop shopping", reduced costs, and a unified multi-functional support team that comes with co-location. Others believe that some support functions, especially business support functions, are "transportable". Benefits of RSCs may be realized sooner and more economically if Area Offices were allowed to specialize around their existing strengths.

5.2.b Co-locate clinical and public health functions together in a unified RSC as practical. Whether professional functions can be co-located depends on the solution to recommendation 5.1.b.

5.3 The Director, with input from Tribes and Indian organizations, shall appoint a Phase II implementation team for Area level restructuring. In implementing the IHDT recommendations, the number, location, and geographic service range for RSC should be determined. A plan identifying these details shall be submitted to the HHS and Congress through the Director, IHS. See Section 4.2 for more details.

The IHDT has proposed the design framework for consolidation. It did not have sufficient time during its brief charter to assess technical factors that must be considered in planning a reconfigured regional support

system. It did propose some objective criteria to be used in making these decisions. The IHDT members believe that following such criteria in deciding details for implementing RSCs will produce a plan that is appropriate and fair.

5.4 The following selected professional functions and resources shall be consolidated, transferred, or regionalized. See recommendation 5.1.b.

- Maternal & child health,
- Behavioral health (i.e., mental health, social and alcohol services),
- Community based activities (i.e., public health nursing, community health representatives, etc.),
- Professional consultation and guidance (i.e., dental, nursing, epidemiology, pharmacy, etc.),
- Professional and program development,
- Environmental health, and
- Engineering.

5.5 The following business and administrative functions and resources should be consolidated into RSC:

- Human resources (payroll, personnel, training),
- Acquisition, procurement, commercial contracting,
- Financial and accounting services,
- Property and asset management,
- Supply (if cost effective),
- Technology and tele-communications.

5.6 The IHDT offers 2 structural models for RSC. Each model assumes some consolidation of program and administrative functions from Area Offices and while retaining an Area Tribal liaison function. The IHDT did not reach consensus on one preferable model. The IHDT recommends consulting further with all tribes on this matter.

- Model A: Geographic Consolidation
- Model B: Functional Consolidation

The Phase II restructuring implementation team shall determine the best technical solution for consolidation by using the proposed consolidation criteria (see Sections 4.2.4 and 4.2.5).

The IHDT did not reach consensus on one model. The models are described and illustrated in the Chapters 2 and 4. The various advantages and disadvantages of each structural model are listed also. It recognized that a full assessment of technical factors and

the proposed RSC criteria will be important considerations in selecting a model or combinations of models for RSC. The IHDT recommended consulting with stakeholders before making final selections.

5.7 The IHDT offers 2 structural models for Self-Determination contracting:

- Functions could be included as part of a RSC,
- Functions could be consolidated into a Self-Determination service center specializing exclusively in contracting for all tribes.

The Phase II restructuring implementation team shall determine the best technical solution for consolidation using the proposed consolidation criteria (see Sections 4.2.4 and 4.2.5).

The IHDT will monitor this closely. The IHDT did not reach consensus on one model. The IHDT recommends consulting further with all tribes on this matter.

3.1.6 For Structural Changes at Headquarters, the IHDT Recommends:

6.1 Simplify the Headquarters organizational structure consistent with the new leadership roles and core functions. Three offices are recommended:

- Office of the Director,
- Office of Health Support, and
- Office of Administrative Support.

This approach reduces layers and bureaucracy, saves FTEs and dollars, and focuses on new leadership roles. It is consistent with the Director as a political appointee reporting to the Secretary, HHS. It minimizes the number of IHS staff that must be located at Headquarters East.

6.2 Streamline and downsize Headquarters by redeploying all operational and field support functions and resources to Area Offices and/or RSC.

The IHDT recommend that the Director act expeditiously on restructuring Headquarters. A possibility is to delegate functions and staff to Headquarters West and begin converting it to a RSC as a demonstration project.

6.3 Focus the new streamlined Headquarters on the following core functions:

- Leadership for clinical and public health,
- Advocacy and voice for the I/T/U system,
- Broad health policy, planning, and priorities,
- Network with other Federal agencies, State, and County governments for additional resources
- Consultation and intergovernmental liaison with Tribal Nations
- Budget formulation and justification,
- System performance evaluation.

6.4 Establish an Office of Self-Governance for Title III compacting outside IHS to serve as impartial arbiter during negotiations.

3.1.7 For Transitioning to the new Indian health system, the IHDT recommends:

7.1 The Director should demonstrate leadership in restructuring all of IHS by restructuring Headquarters expeditiously. Establish a Phase I Headquarters restructuring implementation team to carry out the IHDT recommendations. This team should begin to implement recommendations immediately.

The IHDT believes that consensus exists to restructure Headquarters. The Director can establish the tone for the entire restructuring effort by acting expeditiously with respect to Headquarters functions.

7.2 Demonstrate the proposed restructuring concepts by beginning to redeploy and convert some functions and resources from Headquarters to establish a pilot project for a RSC. The IHDT noted the potential for a pilot center in the Southwest given the location of Headquarters Offices in Albuquerque, N.M., Tucson and Phoenix, Arizona and the four Area Offices in the region.

7.3.a Establish a small Phase II area restructuring implementation team to complete technical planning for area restructuring and begin implementation. The Phase II implementation team shall have approximately 10 members appointed by the Director with at least 5 members from the IHDT for policy continuity.

7.3.b The Phase II implementation team shall, under the oversight of the IHDT, resolve and act on the following:

- Determine the number, location, and geographic service areas for the proposed RSC

- Refine the RSC decision making criteria proposed by the IHDT
- Assess technical requirements for RSC
- Project contracting and compacting trends
- Apply criteria to determine which Area Office and Headquarters functions to consolidate and pool resources
- Apply criteria to determine sites for RSC
- Project RSC staffing requirements and operating budgets
- Identify any resources for reallocation to I/T/Us
- Estimate transition and personnel redeployment costs
- Identify barriers to change and options to overcome them
- Plan a time line for transition
- Submit the plan to HHS and Congress through the Director, IHS

7.4 Establish an initiative for employee retraining and information sharing to facilitate the transition to a new system.

7.5 The IHDT intends that any Headquarters and Area Office resources gained from efficiencies resulting from consolidation and restructuring shall be reinvested into services at the I/T/U level. Implementation teams shall identify a minimum goal of 25 percent of Headquarters and Area Office resources (using FY 1995 as the baseline) for reallocation to the I/T/Us.

Resource reallocation to I/T/Us may include:

- Headquarters and Area Office resources to carry out functions transferred to IHS operated service units, Title I self-determination contracts, or Title III self-governance compacts, and/or
- Headquarters and Area Office resources gained from restructuring efficiencies and downsizing.

The IHDT strongly endorses further decentralizing control of resources to the local I/T/U and the investment of those resources into additional patient and community services. It recommends the 25 percent reallocation goal to highlight this important principle. The IHDT recognizes that some flexibility must be exercised in meeting this overall goal.

7.6 To the extent practical, I/T/Us shall share proportionately in Headquarters and Area Office resource reallocation resulting from consolidation except for those that already receive appropriate shares under a Title I self-determination contract or Title III self-governance compact.

The intent is for I/T/Us that are serviced by Headquarters or Area Office operated functions to share proportionately in any resource reallocation

resulting from restructuring of that function. For instance, an IHS service unit that is now serviced by Area Office personnel would share proportionately in any reallocation resulting from consolidation of personnel functions into an RSC. A Title III self-governance compact that now receives its share of Area Office personnel account would not receive additional shares as a consequence of consolidating remaining personnel resources into an RSC.

3

IMPLEMENTATION

The IHDT recommends that the structural and operational recommendations to the Indian health system be implemented over the next several years. Implementation is to occur in two phases. The first phase is to begin early in FY 1996 and is to be completed in 1997. This phase involves changes to Headquarters structure and operations resulting in a smaller and more efficient Headquarters. The second implementation phase is to begin later in FY 1996 and is to be completed in 1998. This phase involves Area level restructuring

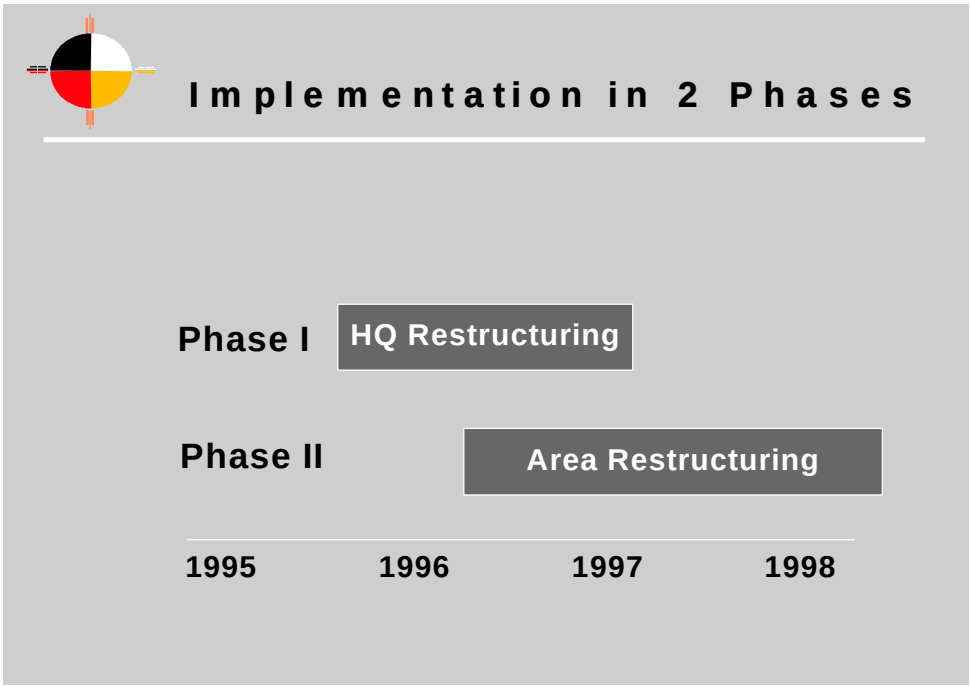

Figure 19

resulting primarily in consolidated administrative functions. The IHDT will monitor the implementation of the recommendations and continue in an active role in designing a new Indian health system.

4.1 Phase I -- Restructure Headquarters

The first phase of implementing the new IHS is to restructure Headquarters functions. The IHDT recommends that the Director, IHS, begin this implementation phase immediately. The feedback on the IHDT recommendations indicates agreement from Tribes and IHS employees for expeditious restructuring and for Headquarters to operate the core functions as proposed in Recommendation 6.3. The intent is to restructure all Headquarters functions no matter where they are located. Figure 20 contains a map identifying where Headquarters functions are located and the number of Federal FTEs performing those functions as of September 1995.

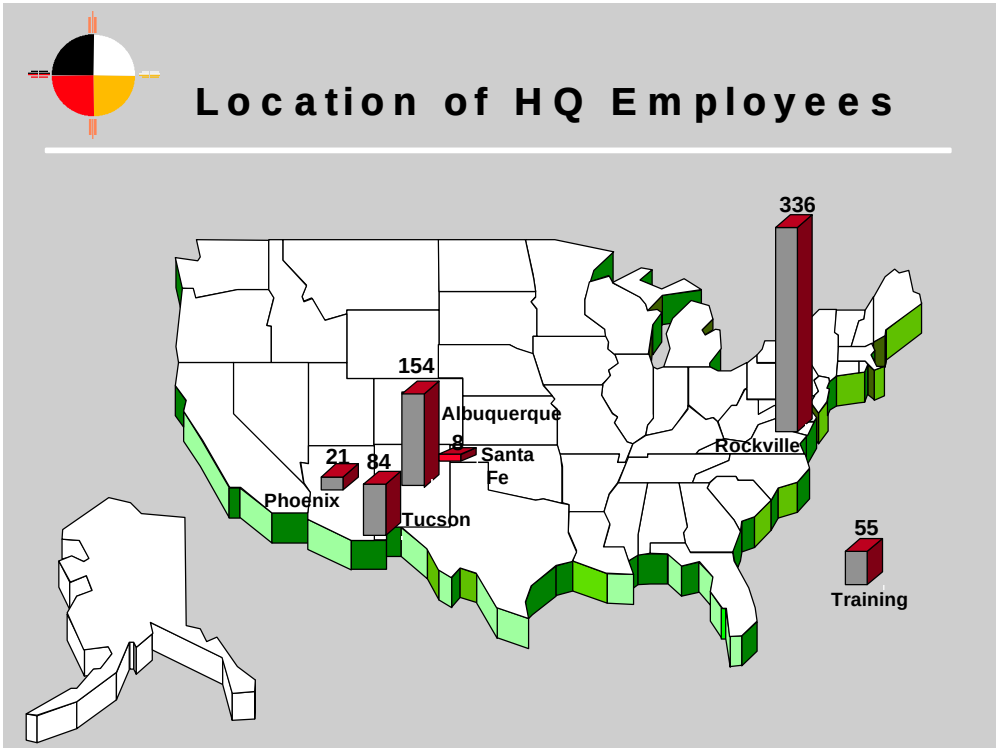

Figure 20

4.1.1 Headquarters Restructuring Implementation Team

The IHDT recommends that the Director, IHS, establish a Headquarters restructuring team. The team is to accomplish a planned approach for implementing Headquarters restructuring with smooth transitioning of resources and operations. The team is to be managed by a senior IHS official and would

be composed of about 5 people. The team will consult as appropriate with the local bargaining unit, conduct detailed analysis, identify the needed resources to perform the proposed core functions, and produce an implementation plan with emphasis on transition management. The implementation plan will specify major milestones to be achieved in FY 1996. The IHDT recommends immediate implementation of actions for which the Director, IHS, already has authority to do and for the Director, IHS, to seek approval for actions requiring approval by the Secretary, HHS.

4.1.2 Headquarters Redeployment Strategies

The IHDT recommends a review of all Headquarters organizational units in relation to the proposed core functions. The organizational units are to be consolidated and simplified accordingly. Operational functions are to be identified for delegation to the Area level or the RSC. The IHDT recommends a

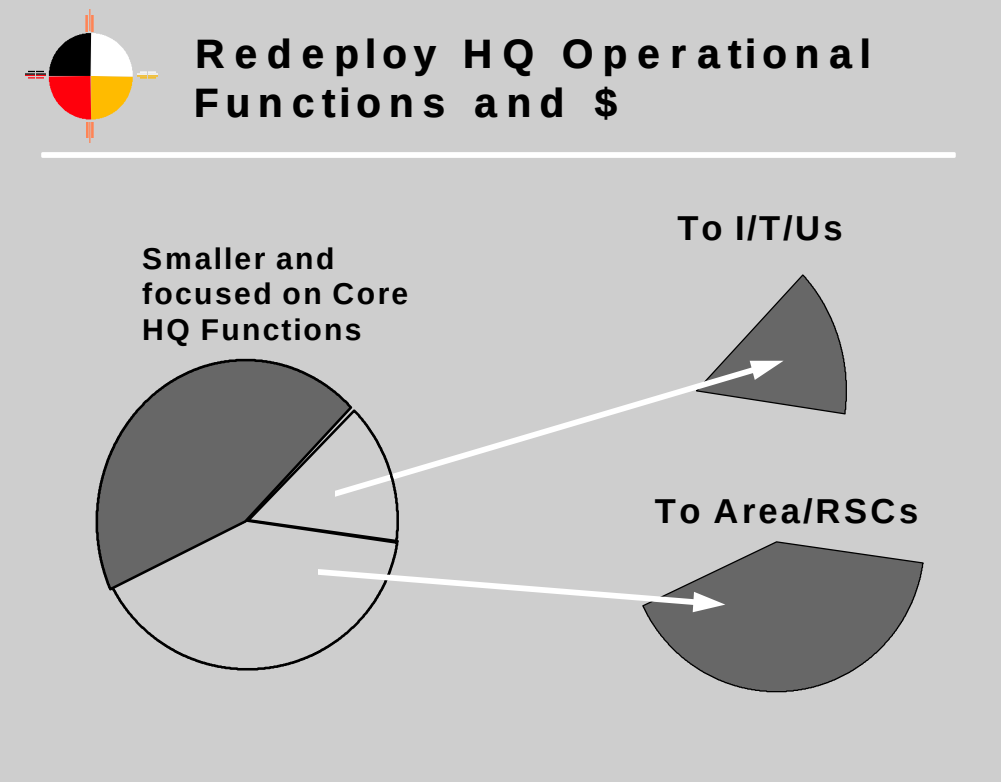

Figure 21

target to deploy at least 25 percent of Headquarters resources into patient and community services. Figure 21 illustrates possible transfers of functions, dollars, and FTEs from Headquarters to I/T/Us, Areas, and the RSC.

4.1.3 Headquarters FTE Redeployment

The IHDT recommends that Headquarters FTE that work in field support will be

redeployed. In FY 1993, Headquarters FTEs totaled 742. As of October 1995, Headquarters FTE was 612. The Headquarters Federal FTE streamlining targets is 500 FTE in FY 1997. This would be a 33 percent reduction since FY 1993. The IHDT recommends additional redeployment and downsizing of Headquarters FTE as functions are transferred to RSCs or Areas. The IHDT expects the implementation team to set an FTE target that is less than 500 based on the recommended core Headquarters functions and further transfers of Headquarters functions to tribes under Title I contracts or Title III compacts. Figure 22 illustrates Headquarters FTE reductions to date, the Federal streamlining target, and a lower FTE target expected by the end of Headquarters restructuring.

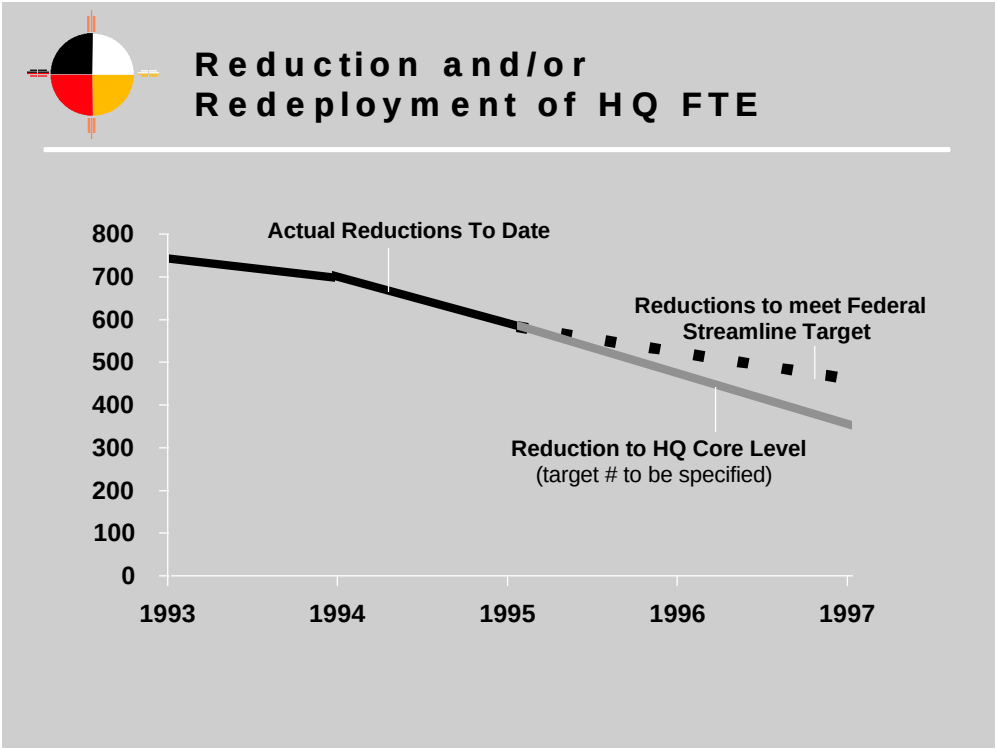

Figure 22

4.1.4 Simplified Headquarters Structure

A more efficient Headquarters structure will require streamlining organizational units and reducing administrative layers. The IHDT proposes three primary Headquarters offices. See Figure 23. Functions that are not in the proposed core functions are expected to be delegated to Areas and/or to RSCs. Figure 24 identifies recommended core functions.

Figure 23

Figure 24

4.2 Phase II -- Restructure Areas

The IHDT recommends restructuring Area level functions as the second phase of implementing the new IHS design. According to the feedback, consolidation, in general, is recognized as necessary for cost effectiveness. The feedback indicates that there is less agreement by Tribes and IHS employees as to how and where consolidation should occur. The IHDT does not propose a single model to replace the existing configuration of Area Offices. A full assessment of technical factors was beyond the scope of the IHDT charge, however, it is agreed that some functions may be performed better at levels other than Areas. Figure 25 illustrates how Area Offices may be streamlined by placing functions where they are best performed to support the I/T/Us. Some factors needing assessment are the functional capability for RSC, staffing configurations to perform the functions, and the location criteria for RSC and its application.

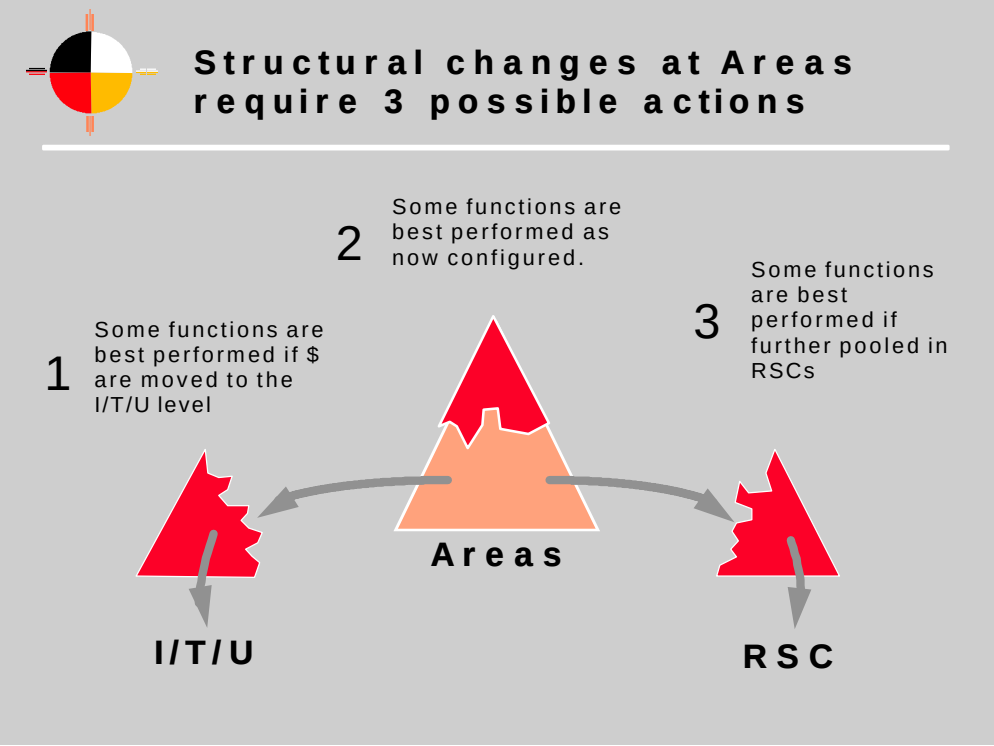

Figure 25

4.2.1 Phase II Area Restructuring Implementation Team

The IHDT proposes that an Area level restructuring implementation team be established. The team is to develop a detailed implementation plan to carry out

the Area level restructuring recommendations as proposed by the IHDT. The team will be composed of approximately 10 members of which 5 are IHDT members. The team will function under the guidance of the IHDT.

4.2.2 Restructuring into RSCs

Options are to be proposed for consolidating administrative functions now located at Area Offices and Headquarters. The feedback indicates that administrative functions are most appropriate for regional consolidation. The IHDT proposes consolidation of the following selected administrative functions as a minimum: self-determination; personnel; financial services; and procurement.

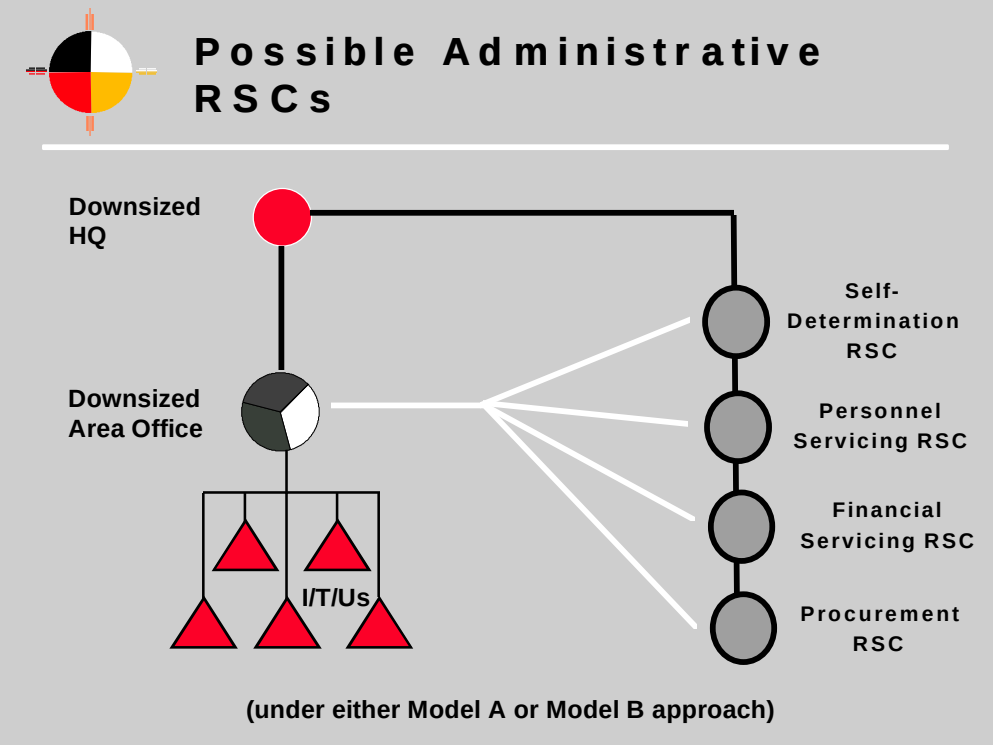

Figure 26

The implementation team should evaluate the circumstances and needs of each Area and propose the model that best meets the needs of the I/T/Us in the Area. Model A, the geographic consolidation model, and Model B, the functional consolidation model, are described in Sections 2.3.3 and 2.3.4 of this report. The team should propose the number, type, and operational roles of RSCs and the functional lines of authority. See Figure 27 for an example of how a procurement RSC might work.

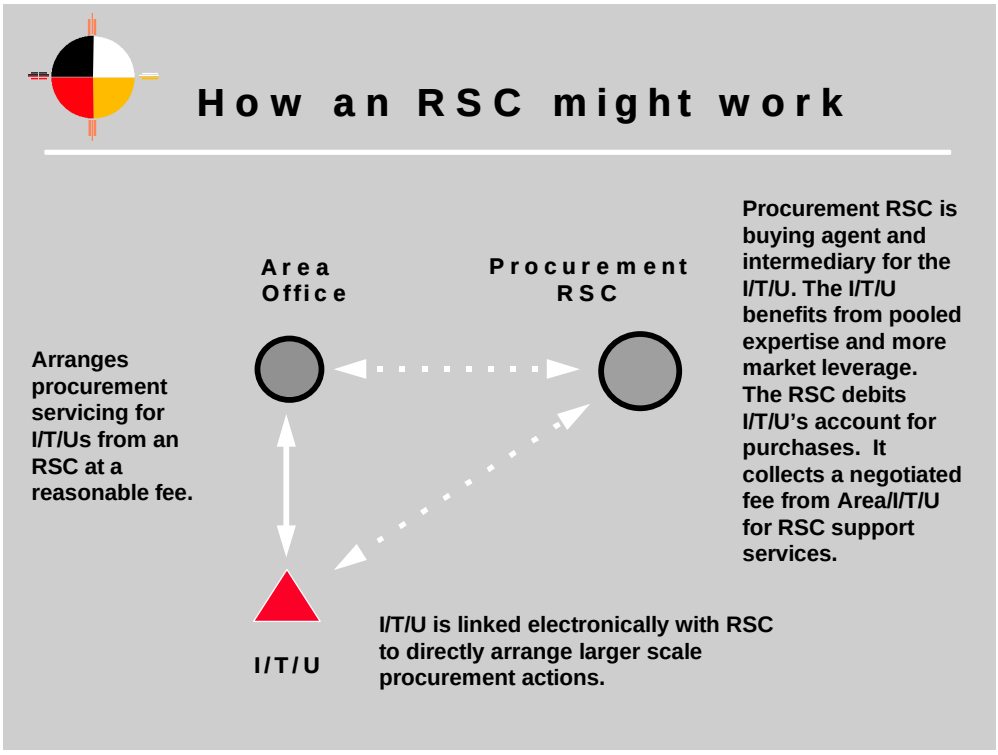

Figure 27

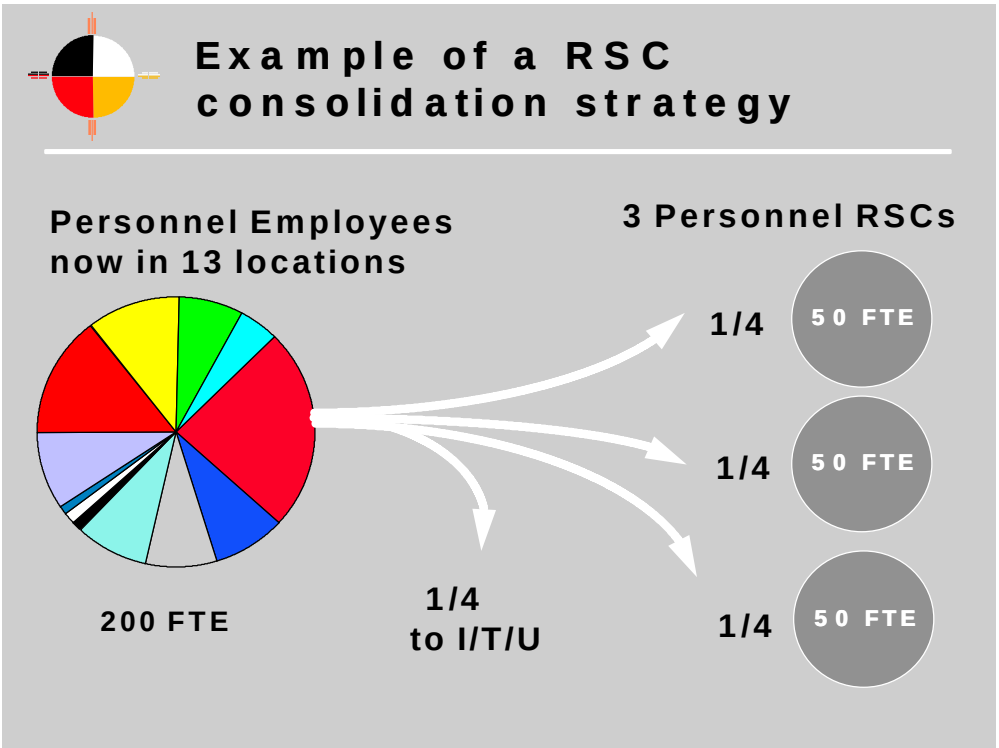

Figure 28

The IHDT proposes a target of 25 percent of Area level administrative resources be deployed to services at I/T/Us. The IHDT intends that any Headquarters and Area Office resources gained from efficiencies resulting from consolidation and restructuring shall be reinvested into services at the I/T/U level. See Figure 28 for an example of how this might occur if personnel operations were consolidated into 3 RSCs.

4.2.3 Area FTE Redeployment

As a result of Federal employment ceilings, the Director, IHS, has selected the targets for reducing or redeploying an additional 414 FTEs from Area Offices by FY 1997. Area FTEs totaled 2,802 in FY 1993. Areas have reduced FTEs by 708 during FY 1994 and 1995. The targets will reduce Area FTE levels to 1,680 FTEs by FY 1997 reflecting a 40 percent reduction since FY 1993. Additional redeployment and downsizing may occur by transferring Area level functions to

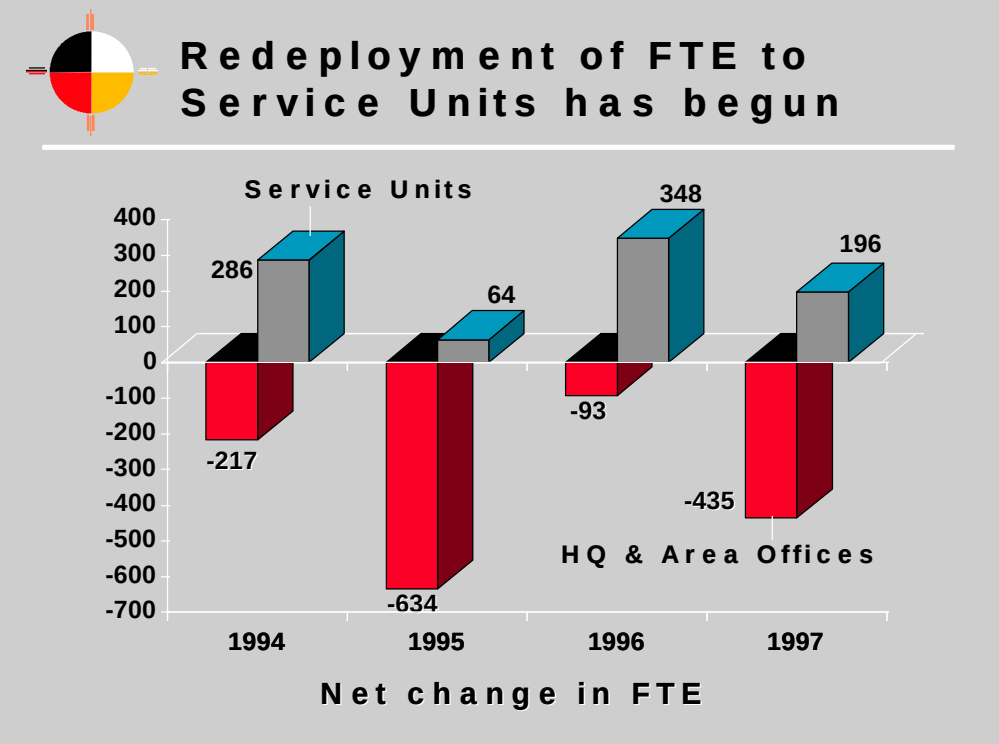

Figure 29

RSCs or as more Headquarters functions are transferred to tribes under Title I contracts or Title III compacts. The IHS projects a net shift of FTEs from Headquarters and Areas to I/T/Us through FY 1997. See Figure 29. It may not be possible to absorb FTE reductions beyond those planned for FY 1997 without reducing FTEs in I/T/Us. Moreover, it may be necessary to redeploy FTEs from I/T/Us to staff replacement facilities that are scheduled to open after FY 1997.

4.2.4 Phase II Consolidation Criteria

Criteria for Consolidation of Area Office and Headquarters Functions

Factor	Rationale	Measure	Threshold
Portion of the Area Office Programs in Contracts or Compacts	Transfer of responsibilities and resources to tribes reduces functional economies of scale in Area Offices. Some highly affected Areas no longer retain sufficient expertise to sustain an economical level of services.	Percent of an Area's budget in Title I contracts or Title III compacts.	Range: 1) >75% : Consolidate 2) 50-75% : Consider Consolidation 3) <50%: Consider together with other factors
User Population Served	Smaller user populations imply reduced economies of scale.	IHS User Population - Federal service units - Contracts/Compacts	Range: 1) < 50,000 : Consolidate 2) 50k-100k : Consider together with other factors
Tribes Served	Overall costs are reduced if spread over a larger #.	Number of Tribes	Range: 1) <5 : Consolidate 2) 6-20 : Consider Consolidation 3) >20 : Consider together with other factors
Proximity of Area Offices (Duplication)	Area Offices in the same geographic region are perceived as duplicative.	Miles between Area Offices	1) < 300 miles : Consolidate
High Costs	Structural changes are often necessary when costs of maintaining services in the existing system exceed the budget.	Budget and Projected Costs of Functions	Range: 1) Budget < 85% of costs 2) 85%-100% : Consider Consolidation
Ability to Sustain Services with Downsized Staff	If $ and staff losses create gaps in coverage or makes services unfeasible, consider structural consolidations to obtain necessary critical mass.	Management Standards and Judgement	Range: 1) Function uncovered : Consolidate 2) Functionality is imperiled: Consolidate
Ratio of Area Staff to I/T/U Staff	High or low ratios indicates a problem that may require consolidation. (I.e., high rations may occur when tribes take over I/T/Us, low indicates lost staff.)	Ratio of AO (or function) staff to total I/T/U staff served.	Range: 1) High : Consolidate 2) within norm : Consider other factors 3) Low : Consolidate

Factor	Rationale	Measure	Threshold
Change Opportunities	When any major changes in the system occur, consider consolidation as part of the change.	Variable	Judgement

4.2.5 Site Selection Criteria

Criteria for Selecting Regional Support Center Sites

Factor	Rationale	Measure	Threshold
Coverage and Costs	Determine the number of RSCs to obtain critical mass for coverage of functions and economies of scale from consolidations.	Minimum size (staff and/or $) to achieve desired pooling for coverage and economical costs	Range: develop technical criteria
Equal Size RSCs	Achieve a better balance of coverage and lower costs, each RSC should serve approximately equal number of tribes, budget, employees, etc.	Number of tribes Budget Employees	Range: Divide among RSCs equally to the extent practical
Existing Capability and Demonstrate Expertise and Excellence	It is better to establish RSCs at existing sites to take advantage of strengths if feasible. This is more critical if Model B: Consolidation by function is selected.	Variable Experience and Judgement	Range: (refine) Rank existing Area Offices by capacity, expertise, etc.
Air/Ground Transportation	A transportation “Hub” offers greater access, timeliness, and reduced costs of travel and transportation.	Rank by the number of scheduled commercial air flights and average cost to I/T/Us served.	Range: (develop technical criteria) 1) Limited access 2) Moderate access 3) Excellent access
Communications Infrastructure	Telecommunications linkages and infrastructure are important for RSCs to link electronically with remote I/T/Us they serve.	Number of Tribes	Range: (develop technical criteria) 1) Limited 2) Sufficient 3) Excellent
Availability of AI/AN Workforce	Maximum employment opportunities for AI/ANs should be maintained.	Number of AI/AN population residing within 50 miles of site	Range: (refine) 1) < 5,000 : Limited 2) 5k-15k : Sufficient 3) >15,000 : Excellent

Factor	Rationale	Measure	Threshold
Local Cost Factor	Potential RSC sites differ in business costs and the local cost of living index. Lower cost sites are preferred if other essential requirements are met.	Local CPI Index (business)	Range: (develop and refine) 1) Below Avg. : Good 2) Above Avg. : Poor
Availability and Cost of Existing Space	Use existing space or lease arrangements if feasible and less costly than prevailing market rates.	Amount of Available space and cost relative to market rates per square foot.	Range: (develop and refine)
Natural Regional Groupings	Appropriate groupings should preserve geographic proximity, tribal/cultural similarities, functional similarities (i.e., contract vs. direct) to the extent possible	Geographic proximity Tribal cultural similarity Functional similarity	Range: (develop measures or seek submissions from organizations such as the NIHB.)
Tribal Consultation	Obtain tribal input as part of the decision making process	Tribal input	n/a

4

COMMENT ON DRAFT REPORT

5.1 Feedback

As mentioned early in this report, the IHDT was determined to turn feedback from the stakeholders in Indian health into participation in the design of a new IHS. The stakeholder assessments about what needs to be done to achieve a system that works better for Indian people formed the basis for the Tier II workgroup proposals and the IHDT's preliminary recommendations. The patients and employees assessments about how the system should change are documented in Chapter 2 of this report.

Throughout the design work, a mechanism for two-way communication between the IHDT and the stakeholders has been provided. Design principles, themes, proposals, and the preliminary recommendations were disclosed as they were developed and were refined only after feedback was reviewed. The IHDT planned its October 1995 meeting around the availability of the stakeholders' feedback on the draft report and the preliminary recommendations. The recommendations in this report were prepared after full review and discussion of the feedback received as of October 10, 1995. Feedback received after this date will be reviewed by the IHDT and submitted to implementation teams for discussion in the implementation planning.

The IHDT distributed the draft report to Indian country in August 1995. An estimated 2,000 draft reports and 1,000 executive summaries were distributed to tribal leaders, tribal health directors, national Indian organizations, urban program directors, health boards, IHS Area Offices, IHS professional council executive boards, IHS service unit directors, and IHS employees. This

distribution was made by the IHDT and does not reflect additional distributions made by individuals reproducing the draft report or its executive summary.

Stakeholder feedback is low compared to the amount of copies distributed. As of November 1, feedback was received from 40 sources representing tribal governments, health boards/corporations, IHS staff at Headquarters, Area, and service unit levels, one IHS national professional council, and one national Indian organization. A list of sources is found in Section 7.2 in the Appendix.

5.2 Themes in the Feedback

The IHDT studied the feedback received on the draft report in its October 1995 meeting. Certain themes emerged and are summarized below.

5.2.1 Positive Presentation

All but one source is positive about the report presentation--writing style, organization, and scope. Sources complimented the work of the IHDT and recognized the difficulty of arriving at the proposals made. It appears that sources agree that change is needed. The BIA experience with budget cuts underscored the recognition that change is imminent.

5.2.2 Principles and Strategies Supported

Feedback supports the overall design strategies for changing the IHS levels above the I/T/Us to a role of support instead of controlling, and investing savings resulting from Federal downsizing into services. Feedback supported, the IHDT principles and the proposed changes to the IHS mission and goal statements.

5.2.3 Clarify the RSC Concept

Positive responses were received for most of the preliminary recommendations. Feedback varied for specific preliminary recommendations especially those pertaining to the proposed RSCs. Most of the changes to this final report are directed at clarifying the RSC concept. The feedback requested details about some concepts presented in the report. Such requests are not surprising in that the IHDT, as an overall guiding body, had presented broad framework for change and had chosen not to engineer specific details. Under the continuing guidance of the IHDT, specific details are to be engineered during the implementation phase.

5.2.4 Consolidate Elsewhere

The feedback supported the principle of consolidation; however, consolidation was viewed more positively as applied to others. For example, Area Office consolidation was strongly supported by the source if applied to other Area Offices. Sources readily suggested specific Area Offices for consolidation while leaving their own in tact. It appears that sources understood that it is advantageous to consolidate in an environment of limited resources and increasing costs, but it is acceptable when it happens elsewhere.

5.2.5 Consolidation of Clinical TA Questioned

A general concern about program support technical assistance located at proposed RSCs or consolidated Area Offices is that knowledge would be compromised about unique tribal health needs. This concern is cited regarding the location of RSCs or consolidated Area Offices if they were located far from the existing Area Office.

5.2.6 Consolidation of Administrative Functions Is More Acceptable

Sources appear to be comfortable about consolidation as it applies to administrative functions. It appears that administrative functions are not regarded as needing specialization by Area or by tribe. Comments implied that consolidating administrative functions into RSCs may be viewed more positively than consolidating program support technical assistance.

5.2.7 Decrease Administration

Sources supported decreasing the IHS administration and increasing health care services and program support technical assistance.

5.2.8 Network With Outside Agencies

The IHDT report focused on internal redesign with the resources known to be available. Networking with other Federal agencies, States, and private sources for resources sharing must be addressed in the implementation phase.

5.2.9 Environmental Health and Construction

The IHDT and its workgroups did not address environmental health services or facilities planning and construction. These components are to be addressed in

the implementation phase of the redesign as part of the public health and prevention component.

5.2.10 Indian Health Data

The means to obtain data needed on Indian health status is to be addressed in the implementation phase.

5.3 Action Taken in Response to Feedback

#	Feedback	IHDT Action
1.1	Feedback endorsed the recommendation.	No change to the recommendation.
1.2	Feedback indicated support for greater I/T/U budget reprogramming authority and additional language re: Title III authority.	Recommendation changed to reflect 100% reprogramming authority and reference Title III authority.
1.3	Feedback endorsed the recommendation.	No change to the recommendation. The IHDT did not accept specific language change that would appear as a directive to the I/T/U.
1.4	Feedback indicated support for fewer performance indicators.	Recommendation changed - stronger verb.
1.5	Feedback endorsed the recommendation.	Recommendation changed - stronger verb.
1.6	Feedback endorsed the recommendation.	Recommendation changed - stronger verb.
1.7	Feedback did not justify a change to the recommendation.	Recommendation changed - stronger verb.
1.8	Feedback did not indicate objection to the recommendation.	Recommendation changed - stronger verb.
1.9	Feedback did not indicate objection to the recommendation.	Recommendation changed - stronger verb.
1.10	Feedback endorsed the recommendation.	Recommendation changed - stronger verb.
1.11		Recommendation changed - stronger verb.
1.12	Feedback endorsed the recommendation.	Recommendation changed - stronger verb.
2.1	Feedback endorsed the recommendation.	No change to the recommendation.
2.2	Feedback indicated the need to explain what “revolving” accounts were.	Recommendation changed to eliminate the words “revolving accounts” and the explanation is provided in the body of the report text.
2.3	Feedback endorsed the recommendation.	Recommendation changed to reflect value.
2.4	Feedback did not indicate objection to the recommendation.	No change to the recommendation.
2.5	Feedback endorsed the recommendation.	No change to the recommendation.

#	Feedback	IHDT Action
2.6		No change to the recommendation.
2.7	Feedback indicated that the line authority of the RSC to the Area Director should be clarified.	The recommendation changed to indicate that the RSC would operate independently of the Area Director line authority.
2.8		No change to the recommendation.
3.1		No change to the recommendation.
3.2	Feedback did not indicate objection to the recommendation.	Recommendation changed to reflect that the staff and dollars could be redeployed to delivery sites, Area Offices, and/or RSCs.
3.3	Feedback did not indicate objection to the recommendation.	No change to the recommendation.
3.4	Feedback indicated that the recommendation be strengthened.	Recommendation changed to reflect a stronger verb usage.
4.1		No change to the recommendation. IHDT strongly believes that redesigning the local I/T/U is to be decided at the local level.
5.1.a.	Feedback varied on the location of RSCs. The concept of consolidating functions was not opposed in general. There appeared to be more support for regionalizing administrative functions rather than program functions.	Recommendation changed to separate the regionalization for administrative functions from regionalization of program functions, and to transfer the engineering details of regionalization to the implementation phase of the design process.
5.1.b.	Feedback varied on the location of RSCs. The concept of consolidating functions was not opposed in general. There appeared to be more support for regionalizing administrative functions rather than program functions.	Recommendation changed to separate the regionalization for administrative functions from regionalization of program functions, and to transfer the engineering details of regionalization to the implementation phase of the design process. The recommendation was enhanced by providing 3 options.
5.2.a	The concept of consolidating functions was not opposed in general. There appeared to be more support for regionalizing administrative functions rather than program functions.	Recommendation changed to separate co-locating administrative functions from co-locating program functions.
5.2.b	The concept of consolidating functions was not opposed in general. There appeared to be more support for regionalizing administrative functions rather than program functions.	Recommendation changed to separate co-locating administrative functions from co-locating program functions.
5.3	Feedback varied as to whether an implementation team was necessary.	Recommendation changed to a stronger verb and clarifying that the implementation team would be addressing implementation below the Headquarters level. The IHDT will continue in its role of overseeing the process.
5.4	The concept of consolidating functions was not opposed in general. There appeared to be more support for regionalizing administrative functions rather than program functions.	Recommendation changed to include a stronger verb and to define other restructuring options in addition to regionalization.

#	Feedback	IHDT Action
5.5	The concept of consolidating functions was not opposed in general. There appeared to be more support for regionalizing administrative functions rather than program functions.	Recommendation changed to a stronger verb.
5.6	Feedback indicates that downsizing is not opposed, but the actual model to be proposed is of interest.	Recommendation changed to refining two structural models and clarifying that the Phase II Area restructuring implementation team shall determine the best technical solution for consolidation and the models.
5.7	Feedback indicates that downsizing is not opposed.	Recommendation changed to clarifying that the Phase II Area restructuring implementation team shall determine the best technical solution for consolidation.
6.1	Feedback indicates that simplifying the Headquarters offices is acceptable.	No change in the Recommendation.
6.2	Feedback indicates that simplifying the Headquarters offices is acceptable.	No change in the Recommendation.
6.3	Feedback indicates that simplifying the Headquarter offices is acceptable.	Recommendation was changed to expand networking to include other governments.
6.4	Feedback indicates concern about services delivered by Title III tribes being given a higher echelon status that Tribes choosing direct service and or Title I service.	No change in the Recommendation.
7.1	Feedback indicates support for this recommendation.	Recommendation was changed to include the establishment of a Phase I Headquarters restructuring implementation team.
7.2	Feedback included a Navajo Nation resolution opposing any action to relocate services now provided from the Navajo Area Office.	No change in the Recommendation.
7.3	Feedback indicates support for establishing an implementation team.	Recommendation was changed to include the establishment of a Phase I Headquarters restructuring implementation team and a Phase II Area restructuring implementation team.
7.4	Feedback indicates concern about employee buy-in the implementation and transition phases of restructuring.	No change in the Recommendation since it identifies the issue of employees and transition. The implementation phase is expected to address this issue more thoroughly.

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CREDITS

The Co-Chairs of the IHDT are grateful to the members of the IHDT in guiding the process that resulted in this report. Each member offered a unique perspective and body of knowledge and experience that contributed to the design of a new health care system for Indian Country. The IHDT benefited from the experience of Mr. Gerald H. Ivey and Ms. Eleanore Robertson who served as advisors to the IHDT. The unity achieved by the IHDT is an extraordinary example of partnership working for Indian Country. They applied Indian values to a process to bring about organizational change so that the patient comes first.

The Co-Chairs are thankful to the members of the Tier II workgroups that supported the IHDT. The workgroup members formulated the ideas for broad functional areas that later became the recommendations in this report. Each member gave willingly of his or her expertise to improve the quality of care and to improve the operational functions that support delivering that care.

The Co-Chairs thank the liaisons in each IHS Area Office. They helped the IHDT distribute information about IHDT activities and work to the stakeholders in Indian Country. Their assistance facilitated much of the feedback incorporated in the preliminary recommendations.

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6

APPENDICES

7.1 Technical Workgroups Assess and Propose Agency Improvements

Tier II workgroups were charged to assess the status of various aspects of the existing system as a step in developing proposals for improving the system. The initial concepts were generated by Tier II workgroup members in March. The IHDT discussed the initial possibilities and suggested some of them be explored further. These same concepts were submitted to Tribal leaders to obtain their feedback and any additional ideas on design efforts.

The design concepts reflect six broad functional areas of providing health care to Indian people. These operational areas are self-determination and Federal operations; clinical and public health operations; business/administrative/budget operations; workforce redeployment; information resources infrastructure; and Agency design, leadership, and advocacy. The findings and conclusions from these assessments are summarized below.

7.1.1 Tier II Workgroup Proposals for Clinical & Public Health Operations

The workgroup endorsed two essential principles. First, that the "comprehensive health system" for AI/ANs must include a "public health"

component. The public health model is more comprehensive than the medical model approach which is limited to the delivery of care by doctors, nurses, or others to individuals who visit a hospital or clinic. In addition to these essential services, the public health model includes community outreach to address health promotion and disease prevention, environmental health, and supporting community empowerment and partnerships. The approach also integrates traditional healing practices and supports local people to become health care professionals consistent with community needs and preferences. This is the model that is responsible for many significant improvements in the health status of AI/AN.

Second, the workgroup concluded the diversity of needs, expectations, and circumstances found among AI/AN communities preclude the application of any single health care model as universally appropriate. Consequently, it did not propose restructuring of field based I/T/U delivery operations. Rather, the workgroup endorsed the recommendations in the widely accepted 1988 Institute of Medicine's report The Future of Public Health as a template for local assessment, decision making, and implementation. The workgroup recognized that the continuing strains on the local I/T/Us will force very difficult actions, however, it strongly believes that such decisions are best made by those most directly affected.

The workgroup then identified requirements for the clinical and public health support capabilities given various health care service levels (community, primary, secondary, tertiary services) together with various mixtures of delivery systems (direct provision by I/T/U staff, case-by-case outside contracts, and capitation agreements). Various alternative support center models were proposed together with criteria for setting regional boundaries, locating support centers, and thresholds for consolidation. Finally, it proposed a number of methods to simplify reporting, accountability, budget structures in a redesigned system.

Clinical & Public Health Options

Options	Pros	Cons
Decentralize to RSC those Headquarters health care professionals and consultants that have field support responsibilities while maintaining a core clinical and public health team at the national level as essential for Indian health advocacy.	◆ Downsizes & reduces layers ◆ Maximizes $ for field support ◆ Support functions are closer to the field, more "in touch" ◆ HQ core clinical & public health team would focus on key support to core agency roles	◆ Relocation costs ◆ Less program expertise at HQ ◆ Possible conflicts in support responsibilities in the field
An Institute of Indian Health, an independent national organization without regulatory or enforcement powers, was posed as an alternative.	◆ Objective & independent of IHS ◆ Repository of AI/AN health consultation expertise ◆ Uniform national availability technical assistance ◆ Could serve a strong national advocacy role for AI/AN	◆ Might not be viewed as downsizing ◆ Uncertain sources of Funding (fee basis from participating I/T/Us?) ◆May be difficult to set up ◆At risk of becoming academic and disengaged from front-line I/T/U support
Maintain a clinical and public health support infrastructure at a regional level a long as direct IHS programs exist or tribes elect to utilize such support services.	◆This conclusion is based on the high turnover and relatively inexperience of health care providers that continue to make up a large percentage of the local I/T/U workforce and the need to orient these providers into the public health paradigm.	◆ FTE downsizing is not as rapid ◆ Maintains a layer above I/T/Us
Consolidate clinical and public health functions of Area Offices in to a smaller number of regions with the necessary complement of staff placed where they can best contribute to the support of the I/T/Us.	◆ Reduces number Area Offices ◆ Saves FTEs ◆ Consolidates to regions with a feasible critical mass of expertise ◆ Maintains integrated clinical & public health support "team" ◆ Clear geographic areas of responsibility ◆ More efficient than is possible if each I/T/U is individually responsible	◆ Relocation costs ◆ Disruption of historical offices ◆ Broader and less homogenous regions ◆ Less local I/T/U control and flexibility than if all functions were responsibility
Criteria for Setting Up Regions: ◆ % contracted/compacted ◆ # & distribution of I/T/Us ◆ Tribal preferences ◆ Size for critical mass ◆ Geographic size and access ◆ Workloads ◆ Locations of existing staff	◆ Objective standards to logically plan support centers ◆ Driven by system improvement rather than by politics ◆ Consistent and fair	◆ Must leave flexibility for unique circumstances. ◆ Data collection costs
Threshold Criteria for Regional Consolidation: ◆ <20% of $ to direct IHS ◆ < 5 I/T/U ◆ < 50,000 population ◆ < 5 tribes ◆ Ratio of support staff to I/T/U staff > 1:15	◆ Objective standards to logically plan support centers ◆ Driven by system improvement rather than by politics ◆ Consistent and fair	◆ Must leave flexibility for unique circumstances. ◆ Data collection costs

Options	Pros	Cons
Criteria for Locating Regions: ◆ Access to transportation ◆ AI/AN employment pool ◆ Already existing staff ◆ Proximity to I/T/Us ◆ Tribal Accessibility ◆ Cost of Living/Recruitment ◆ Proximity to infrastructure	◆ Objective standards to logically plan support centers ◆ Driven by system improvement rather than by politics ◆ Consistent and fair	◆ Must leave flexibility for unique circumstances. ◆ Data collection costs

7.1.2 Tier II Workgroup Options for Business & Administrative Support Operations

The Business and Administrative Support Operations Workgroup assessed streamlining and improving essential business support operations (finance, procurement, personnel, etc.). It examined various structural models for reconfiguring the existing support functions now variously performed in 12 Area Offices and by all Headquarters sites. It also examined ways to simplify and streamline internal operations and work processes.

Business and Administrative Options

Options	Pros	Cons
Delegate to the local I/T/U all authorities which are legal and which are cost effective. Delegate these authorities as the local I/T/Us develop capacity; not based on an all or nothing approach.	◆ Empowers local I/T/U control with the flexibility to tailor to local needs and circumstances ◆ Maximize $ for the field ◆ Functions are closer to the field, more "in touch"	◆ Requires local expertise to manage effectively ◆ Some Loss of economies of scale ◆ Legal limits on what authorities can be delegated to local level
Change the culture of IHS administrative offices at all levels to a mission of support and consultation; not control. Support centers should have entrepreneurial incentives.	◆ Gives I/T/Us choice in deciding the source of support that best meets their needs ◆ Improves quality and timeliness of support services ◆ Increases incentives to work with I/T/Us to meet needs ◆ Customer oriented ◆ Reduces bureaucracy and control mentality.	◆ Requires changing of rules, regulations and attitudes of managers and the workforce ◆ Higher risk of mistakes (freedom to change and make improvements also means the freedom to make mistakes)
Create "support centers" in much smaller numbers than the current 12 Area Offices.	◆ Consolidation and pooling is necessary to fill existing gaps in capability and staff as downsizing and contracting occurs. ◆ Reestablishes critical mass of staff and expertise for functional support of I/T/Us ◆ Saves FTEs and $ ◆ Focuses on satisfying the needs of the I/T/U rather than in controlling them	◆ Requires reconfiguring the familiar system ◆ Closing and downsizing of some Area Offices ◆ Relocation costs/redeployment of some staff

Options	Pros	Cons
Specialized Support Center Model - Center of Excellence Approach: Many Area Offices would specialize in 1 or 2 support activities building on existing strengths while downsizing and transferring other functions. Each specialized support center would serve I/T/Us from broader geographic areas. (e.g., a finance support center serving most I/T/Us much might be located at the Oklahoma Area, a third party billing support center might be located in Tucson. Other Area Offices would not retain these functions.	◆ Most Area Offices would continue to exist ◆ Areas continue with a specialized presence but downsized from current levels ◆ Builds on existing strengths - "centers of excellence" ◆ Consolidates capability by function rather than geography ◆ Pools functional expertise to a critical mass ◆ Saves FTEs and $ ◆ Offers choices to I/T/Us ◆ Some I/T/Us could become a support center for a certain function.	◆ Less clear lines of responsibility and accountability (I/T/Us would get support form several locations rather than 1) ◆ Relocation costs/redeployment of some Area staff ◆ Disruption of historical patterns of access and support ◆ Broader and less homogenous service regions ◆Transition and startup cost, efforts, and probable confusion ◆ Impractical for Areas that are already "thin" to immediately develop expanded capability to serve I/T/Us from other geographic regions.
All Inclusive Support Center Model: In this approach, all administrative and business functions would be consolidated under 1 roof in a RSC. (Similar to the existing Area Office concept but in fewer numbers.)	◆ Consolidates capabilities together in one place ◆ Clear lines of responsibility and accountability ◆ Pools functional expertise to a critical mass necessary to support I/T/Us efficiently ◆ Saves FTEs and $ ◆ Allows reconfiguration to reflect regional differences in contracting/ compacting ◆ Less confusion about transition	◆ A majority of existing Area Offices might be closed depending on locations of centers ◆ Relocation costs/redeployment of some Area staff ◆ Disruption of historical patterns of access and support ◆ Requires technology and communications with I/T/Us ◆ Broader and less homogenous service regions ◆ Transition efforts and startup costs
Contract Support Center Model: Tribal, Buy-Indian, or commercial firm sets up a support center and contracts with I/T/Us for certain support functions. Alternative: out-sourcing of selective functions where they may be available without setting up a consolidated contract.	◆ Promotes AI/AN business opportunities ◆ Brings competition to the support services ◆ Tribal preferences ◆ Entrepreneurial ◆ Saves FTEs ◆ Offers choices to I/T/Us ◆ May save $	◆ Availability is unknown ◆ Substantial Federal layoffs ◆ Disruption of historical patterns of access and support ◆ May not save $ ◆ Higher risks if private firms fail ◆ Not all Federal functions could be contracted
Simplify the IHS budget line items and/or allow local I/T/U managers greater flexibility to manage among accounts.	◆ Less micro-management ◆ Allows local I/T/U to match funding to needs ◆ "bean counting" methods are too rigid	◆ Requires approval of Congressional committees ◆ "special interests" will oppose

Options	Pros	Cons
Streamline support processes and reporting requirements. All work and reporting should clearly add value or should be eliminated.	◆ Work that does not add value is not needed ◆ Work simplification saves FTEs ◆ Saves $ ◆ Is essential for a downsized IHS	◆ Disrupts historical practices ◆ Change will take time and automation ◆ Risks protections built up over time.

7.1.3 *Tier II Workgroup Options for Self-Determination & Federal Operations*

The Self-Determination and Federal Operations Workgroup assessed contracting and compacting with tribal governments, designs for a streamlined organization appropriate for such "intergovernmental relationships", and alternative models and functions for Area, regional, or national entities to carry out Title I and Title III activities. The workgroup proposed the following structural options:

Self-Determination Structural Options

Options	Pros	Cons
Congressional appropriations directly to Tribes via a single disbursing office.	◆ Ultimate in streamlining ◆ Minimum Federal overhead ◆ Direct link to tribes	◆ Congress unwilling to budget directly with >500 tribes ◆ Lack of access for problems ◆ No current mechanisms or allocation procedures
A single Headquarters/national office issues Self-Determination contracts Single Self-Governance Office located outside IHS in HHS.	◆ Centralized authority and decision making ◆ Uniform policy and implementation ◆ More consistent negotiations ◆ Less FTEs & bureaucracy ◆ Allows restructuring ◆ More gov.-to-gov. relationship	◆ Decreases geographic access for tribes ◆ Eliminates working relations within Areas ◆ Possibly more difficult buy-back implementation ◆ Unfamiliarity ◆ Tracking of pooled $ for computation of shares ◆ Large national scope ◆ Costs and effort to setup
Regional Office specializes in issuing Self-Determination contracts/compacts	◆ Cost efficient with FTE savings ◆ Decision making authority vested here not at HQ ◆ Consolidates functions and allows critical mass of expertise ◆ More uniform procedures and execution of policy ◆ More consistent negotiations ◆ Reduces HQ functions/ bureaucracy ◆ Clear geographic areas of responsibility and accountability	◆ Unfamiliarity with new system ◆ Cost/effort to setup ◆ Eliminates Area roles ◆ May raise questions about compact/contract share computations ◆ Broader and less homogenous regions ◆ Compact authority would need delegation

Options	Pros	Cons
Area Offices issues Self-Determination contracts/compacts	◆ Familiar to tribes ◆ Closer access than regional ◆ Less cost for relocation ◆ System is in place ◆ Clear geographic areas of responsibility ◆ Tracking of pooled shares is less a problem	◆ Compact authority would need delegation ◆ More costly, less downsizing ◆ Less $ for field services ◆ Less consistent negotiations ◆ Less uniform policies and implementation ◆ Lacks critical mass of expertise in all Areas
Service Unit Issues Self-Determination contract/compacts NOT RECOMMENDED		◆ Maximum costs, FTEs and inconsistency of policies and implementation ◆ Many Legal and technical obstacles

7.1.4 *Tier II Workgroup Proposals for Headquarters Core Functions*

The Headquarters Core Functions Workgroup assessed the essential functions necessary for under a new IHS configuration, one in which the Headquarters roles focuses on national leadership and Indian health advocacy rather than on operations management and field support.

Core Headquarters Options

Options	Pros	Cons
Proposed Core Headquarters Functions ◆ Broad Indian health policy ◆ Indian health advocacy ◆ Strategic planning ◆ Performance evaluation ◆ Budget formulation and resource allocation ◆ Leadership on public health and community oriented primary care model ◆ Central data and technology leadership ◆ Human resource & workforce leadership ◆ Intergovernmental leadership	◆ Focuses on national scope activities and policies ◆ Leaves all operational & management activities to support centers or I/T/Us	◆ Substantial redefinition of Headquarters East
Simplify Headquarters organizational structure consistent with core functions: ◆ Office of the Director ◆ Office of Clinical and Public Health ◆ Office of Support Services	◆ Reduces layers and bureaucracy ◆ Saves FTEs and $ ◆ Focuses on new leadership roles instead of managing, directing, or supporting operations ◆ Consistent with the Director as appointee reporting to the Secretary ◆ Minimizes # of FTEs that must be located in DC area.	◆ Substantial redefinition of Headquarters East ◆ Must be phased to capabilities of support centers initial step could involve delegating staff and deploying staff to Headquarters West until new support centers were functional
Delegate management and operational authorities to the support centers. Redeploy staff performing operational management or support roles to the support centers.	◆ Cost and FTE savings ◆ Decision making authority vested in regional centers ◆ Consolidates functions and of expertise at support centers ◆ Professional and administrative staff are closer to the field, “more in touch” ◆All operational issues are closer to tribes, not in DC area	◆ Substantial redefinition of Headquarters East ◆ Must be phased to capabilities of support centers ◆ Initial step could involve delegating staff and deploying staff to Headquarters West until new support centers were functional
Redefine roles and adopt a new nomenclature that describes the changing role of the Director as a leader and advocate rather than operational manager.	◆Strengthens the leadership function and frees the director from operational management duties that undermine leadership effectiveness	◆ Must assure accountability for delegated operational responsibilities

7.1.5 Tier II Workgroup Proposals for Information Resources Infrastructure Support

The Information Resource Infrastructure Workgroup assessed communications and information systems needed support a new configuration of program and administrative support centers that would provide essential support to I/T/Us in more than one geographic area.

Information Infrastructure Options

Options	Pros	Cons
The Indian health information infrastructure of tomorrow should be built upon and evolve from the existing infrastructure. Cost accounting and other business support capabilities are necessary for I/T/Us to be successful with new responsibilities and autonomy. The local I/T/U should have decision making authority to choose and pay for systems that best meet their needs.	◆ Uses existing strengths ◆ Provides a growth path to phase in new capabilities ◆ Patient care components are strong ◆ Decision making authority at local level	◆ Existing systems have several weaknesses ◆ Not uniformly available ◆ Business and management functions are lacking ◆ Private sector billing automation equivalency is lacking. ◆ Many Tribes will be reluctant to switch ◆ Requires substantial investment, I/T/Us will pay as normal business expense
Use Commercial off the shelf (COTS) products if possible. Develop internally only as last resort. RPMS, ARMS and other IHS information systems must be opened to allow integration with commercial products. Cost accounting must be added or purchased.	◆ Open system standards, vendor independence ◆ End user control over the systems they use ◆ Lower costs for COTS	◆ Requires standards for compatibility ◆ COTS may not be available for some needs ◆ Costs and effort to setup ◆ Requires substantial investment, I/T/Us would need to contribute
Locate RSC in a communications hub. Invest in expansion of communications linkages and capacity from support centers to include I/T/Us. ◆ Extend Local Area Networks to I/T/Us ◆ Enhance Wide Area Networks ◆ Offer I/T/Us options	◆ Electronic transmission of information is essential to supporting I/T/Us remotely ◆ Allows I/T/Us to access the best source for services regardless of the location ◆ Saves FTEs and $ in long run	◆ Requires major investment in communications, I/T/Us would need to contribute ◆ Telecommunications infrastructure may be insufficient in very remote areas
Establish and independent Information Technology Advisory Board with broad membership, especially I/T/U users to set priorities, standards, and guide a coordinated investment strategy.	◆ Puts policy development in hands of end users (I/T/Us) ◆ Provides a means to maintain shared standards and approach ◆ Monitors technology advances and advocates for I/T/Us.	◆ Advisory, I/T/Us make final decisions on systems and investment ◆ Costs of supporting the board and meetings

Options	Pros	Cons
Establish a national Indian health data bank to identify AI/AN needs, measure program performance, and track accountability. ◆ Preserve and improve the IHS health statistical systems ◆ Preserve data standards	◆ IHS historical data base is invaluable for monitoring Indian health and in justifying budget requests.	◆ All I/T/Us must participate with the minimum data elements, standards, and reporting for the data bank to be complete.

7.1.6 Tier II Workgroup Proposals for Workforce Redeployment

The Workforce Redeployment Workgroup assessed tools and issues related to redeploying the IHS workforce for the new structural configuration. It also proposed a preferred structural model. Note: Pros and Cons are not provided for issues for which they are not applicable.

Workforce Redeployment Issues

Options	Pros	Cons
The workgroup concluded: ◆ 1/3 of HQ and Area $ will be transferred under Title I & III shares ◆ Budget will not cover inflation ◆ Must reduce by 1,000 FTEs ◆ Additional 1,000 FTEs to staff new/expanded hospitals & clinics ◆ Significant gaps in the workforce will increase if restructuring actions are not taken ◆ Provision of all functions in all Area Offices is no longer realistic ◆ Pooling of resources is necessary to maintain critical mass to perform many functions ◆ Supervisor to employee ratio must be reduced by 50%	◆ Not Applicable	◆ Not Applicable
Redeployment Tools ◆ Temporary waiver of Indian Preference during redeployment (not recommended by IHDT) ◆ Delegation of RIF/RIS authority to Areas ◆ Voluntary Transfer and Relocation ◆ Placement lists for displaced employees ◆ Billet retention (DCP responsibility) ◆ Directed reassignments ◆ Employee education and retraining	◆ Prefer maximum use of voluntary methods ◆ The IHDT believes that Indian Preference is important principle that should not be compromised even for a more effective transition period.	◆ Major restructuring will likely require authorities to take actions that adversely affect employees ◆ All authorities are not currently delegated (RIF/RIS) ◆ RIF/RIS is counter to the Administrations desire to downsize without layoffs

Options	Pros	Cons
Regionalization Considerations: ◆ Lines of authority should go from HQ to regional centers, not under individual Area Directors ◆ Impartial process or board is needed to oversee process of reassignments across Area Offices ◆ HQ East and West should receive all administrative services from a RSC ◆ Telecommunications costs will increase ◆ Training/retraining costs will increase initially ◆ Regional centers require transportation hub access ◆ Availability of skilled AI/AN workforce is important ◆ Consolidations will produce savings for supervisors ◆ Estimates 1/3-1/2 of employees will not relocate	◆ Consolidation of functions allows critical mass of expertise ◆ More uniform procedures and execution of policy and effective quality services ◆Retirement eligibles may opt out	◆ Costs of redeployment will be high: ◆ Change of Station ($18,000 - $36,000 each) higher in Alaska ◆ Severance Pay (average is 1 year salary - $50,000 each) ◆ Lump Sum Leave Payments ◆ Relocation is not an option for some employees
Coordination & Implementation Steps: ◆ Work with employee unions ◆ Maintain Equal Employment Opportunity ◆ Establish redeployment team ◆ Set up communications with employees - morale ◆ Estimate & manage costs of redeployment, etc. ◆ Adjust office space as necessary ◆ Coordinate competitive registers ◆ Coordinate moves ◆ Establish new organizations, functional descriptions, personnel descriptions ◆ Plan time lines for implementation ◆ Public relations	◆ Not Applicable	◆ Not Applicable

7.2 Sources of Feedback

7.2.1 9 Tribal Governments

Tanana Chiefs Conference	Testimony at Oversight Hearing, Senate Committee on Indian Affairs re: Reorganization of the BIA and IHS
Nooksack Indian Tribe	Letter to NIHB
Duckwater Shoshone Tribe	Letter to Director, IHS
Hopi Tribe	Letter to NIHB
Quinault Indian Nation	Letter to NIHB
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians	Letter to NIHB
Aleutian/Pribilof Islands Assoc., Inc.	Letter to Director, IHS
Navajo Nation	Resolution submitted to Director, IHS
Sisseton -Wahpeton Sioux Tribe	Letter to the IHDT

7.2.2 5 Health Boards

Alaska Native Health Board	Testimony at Oversight Hearing, Senate Committee on Indian Affairs re: Reorganization of the BIA and IHS, and Director, IHS, & ANHB Resolution 95-08
Yukon-Kuskokwim Health Corp.	Testimony at Oversight Hearing, Senate Committee on Indian Affairs re: Reorganization of BIA and IHS
Tanana Chiefs Conference, Inc, Regional Health Board	Resolution 95-01 submitted to Director, IHS
Bristol Bay Area Health Corporation	Letter to Director, IHS
Albuquerque Area Indian Health Board	Letter to Director, IHS

7.2.3 24 IHS Employees

13 Headquarters Staff	Written Response to IHS
6 Area Staff	Written Response to IHS
5 Service Unit Staff	Written Response to IHS

7.2.4 1 IHS Professional Council

IHS National Council of Nursing	Written Response to IHS

7.2.5 1 National Indian Organization

National Indian Council on Aging, Inc	Letter to Director, IHS

7.3 CHRONOLOGY OF ACTIVITIES

7.3.1 *What's Happened So Far...*

February 1, 1994	Quality Management (QM) Workgroup on Restructuring Report submitted to the Director, IHS
March 25, 1994	Dr. Trujillo confirmed as Director, IHS
May 23-26, 1994	National Summit on Indian Health Care Reform
June 6-8, 1994	Council of Area/Associate Directors Management Meeting - Vision, Values, Restructuring
August 16, 1994	Council of Area/Associate Directors Recommends Adopting the QM Workgroup's Guiding Principles/Core Values for Restructuring
October 17-18, 1994	Orientation Meeting on Designing a New IHS
November 2, 1994	IHDT Conference Call to plan presentations on Designing a New IHS at the NIHB/IHS Conference
November 15, 1994	1) Vision for the IHS by Dr. Trujillo; 2) "Designing a New IHS" Information Package; & 3) IHS Employee & Patient/Customer Suggestion Form distributed
November 22, 1994	IHDT Panelists Conference Call to discuss NIHB/IHS Conference Plenary/Workshop presentations
November 27, 1994	IHDT Meeting to discuss Plenary/Workshop presentations
November 29, 1994	"Designing a New IHS" Plenary Session, Albuquerque Convention Center
November 29, 1994	"Designing a New IHS" Workshop Session, Albuquerque Convention Center
December 1, 1994	"Designing a New IHS" Listening Session, Albuquerque Convention Center
December 2, 1994	IHDT Meeting, Headquarters West, to discuss impressions from the Tribal/IHS conference
December 9, 1994	IHDT Conference Call to clarify subgroups assignments
January 4, 1995	IHDT Conference Call to brief the IHDT on individual subgroup work
January 4, 1995	Letter to Area/Associate Directors, Health Boards, & Tribal Leaders to confirm IHDT & to obtain input on modifications by Indian leaders on the proposed

	design process & on preparatory activities to assist the IHDT's work
February 8-9, 1995	First Meeting of the formalized IHDT, Albuquerque, NM. Meeting established operating principles, clarified membership commitment, and established 6 Tier II workgroups & 1 subgroup to review the IHS mission.
March 3, 1995	Mission Review Subgroup meeting called by M.B.Skupien and D.Bauman.
March 13, 1995	Co-Chairs Floyd and Davis briefed the Senate Committee on Indian Affairs on IHDT activities.
March 15-17, 1995	IHDT Tier II Workgroups Orientation Meeting, Albuquerque, NM.
March 22, 1995	IHDT Conference Call for Status on Workgroups & to Plan March 28-30 IHDT Meeting Agenda
March 28-30, 1995	Second Meeting of the IHDT, Headquarters West, Albuquerque, NM
April 7, 1995	April IHDT Updates issued
April 10-12, 1995	Clinical and Public Health Tier II Workgroup Meets in Albuquerque, NM
April 18-19, 1995	IHDT Tier II Workgroups Meeting, Albuquerque, NM (Business/Administrative/Budget Functions; Workforce Redeployment; & Self-Determination and Federal Operations)
April 21, 1995	IHS Area IHDT Liaisons Conference Call at 11:00 AM EST
April 24, 1995	Tier II Agency Design, Leadership, & Advocacy Workgroup Conference Call at 11:00 EST
April 28, 1995	Target date for Obtaining Feedback from Indian Country on Initial Ideas generated from Tier II Workgroups
May 8-9, 1995	Tier II Agency Design, Leadership, & Advocacy Workgroup Meeting in Albuquerque, NM
May 9-10, 1995	Tier II Information Resources Infrastructure Workgroup Meeting in Phoenix, AZ
May 11, 1995	IHDT Conference Call to plan May IHDT Meeting
May 17, 1995	Second round of Tier II Workgroups' Catalog of Ideas submitted to IHDT Members for Review
May 24-26, 1995	Third Meeting of the IHDT

June 6-8, 1995	Tier II Workgroup on Clinical and Public Health Operations Meeting in Albuquerque, NM
June 7-8, 1995	Tier II Workgroup on Business/Administrative/Budget Functions Meeting in Albuquerque, NM
June 8, 1995	The IHS Council of Area and Associate Directors endorse the IHDT's Design Themes at its June Quarterly Meeting
June 13-14, 1995	Tier II Workgroup on Workforce Redeployment Meeting in Phoenix, AZ; Tier II Workgroup on Core Headquarters Functions (formerly Agency Design, Leadership, & Advocacy) Meeting, Phoenix, AZ; Tier II Workgroup on Self-Determination & Federal Operations Meeting in Phoenix, AZ; and Tier II Workgroup on Information Resources Infrastructure Meeting in Albuquerque, NM
June 27-29, 1995	Fourth Meeting of the IHDT to review the Tier II Workgroup recommendations and decide on recommendations to forward to Indian Country for review and consultation
August, 1995	The IHDT DRAFT Report is distributed to Indian Country and IHS employees for feedback
October 10-11, 1995	Fifth meeting of the IHDT to review and incorporate the feedback into the recommendations for the final report and to discuss implementation planning.

What's Going to Happen...

November 1995	Prepare the Final IHDT Report and distribute to Indian Country and IHS employees. Announce the members of the Implementation Team.
December 1995	First meeting of the Implementation Team.

7.4 ACRONYMS

The following acronyms are used throughout this document:

AI/AN	American Indians and Alaska Natives
AO	Area Office
ARMS	Administrative resource management system
BIA	Bureau of Indian Affairs
COTS	commercial off the shelf
CPI	consumer price index
FTE	full-time equivalent
HHS	Department of Health and Human Services
HQ	IHS Headquarters as it applies to all Headquarters operations no matter where they are physically located.
HQE	IHS Headquarters as it applies to the office/program located in Rockville, Maryland
HQW	IHS Headquarters as it applies to the offices/programs located outside of Rockville, Maryland, in Albuquerque, New Mexico
HUD	Department of Housing and Urban Development
IHDT	Indian Health Design Team
IHS	Indian Health Service
K	in 000's
Local I/T/U	Site where health care service is provided. The care can be provided by an Indian Health Service site by Federal employees --"I". The care can be provided by a tribe through contracting or compacting --"T". The care can be provided by an urban Indian health program -- "U".
NIHB	National Indian Health Board
OTA	Office of Tribal Activity
PHS	Public Health Service
REGO	Reinvention of Government initiative
RIF	Reduction in Force
RIS	Reduction in Strength
RPMS	Resources and patient management system
RSC	regional support center, as proposed in the IHDT Report that involves consolidation of functions from several Area Offices
SSA	Social Security Administration
SG	self-governance

7.5 GLOSSARY OF TERMS

Area Office - A defined geographic region for IHS administrative purposes. Each Area Office administers several service units.

Centers of Excellence - Specific facilities and/or providers selected to deliver specialized services, regardless of the area of the country in which the service is needed. Generally requires high-tech procedures and highly specialized equipment and staff.

Clinical Services - Services provided by physician assistants, family nurse practitioners, laboratory, X-ray, optometry, physical therapy, pharmacy, audiology, and podiatry.

Compact - A legal instrument which defines a government-to-government relationship between signing parties. The instrument used by the Secretary, HHS, and the tribal governing body to agree to terms and conditions to plan, conduct, consolidate, and administer health programs, services, and functions of the IHS, and to redesign services and reallocate funds (within appropriations) within the total amount specified in the annual funding agreement.

Consensus Decision Making - Decisions arrived at by consensus; not by a counting of majority votes. Agreement is achieved through discussion and negotiation until all members can accept the group decision.

Contract Care - Services not available directly from IHS or Tribes that are purchased under contract from community hospitals and practitioners

Contracting - An agreement entered into by a Tribe or tribal organization and the appropriate Secretary

Core Capabilities - Skills common to most companies in a particular business
Centers of Excellence - Specific facilities and/or providers selected to deliver specialized services, regardless of the area of the country in which the service is needed. Generally requires high-tech procedures and highly specialized equipment and staff.

Entrepreneurial - Approaching business from the point of having a product that is marketable and maintaining mass appeal for that product in the market.

Local I/T/U - The site where health care services are provided to users. The site may be a local IHS facility where care is provided by Federal employees. The site may be a tribally compacted/tribally contracted. The site may be an urban Indian health program.

Managed Care - A process for financing and delivering medically necessary, appropriate, high quality, and cost effective health services in a competitive market.

Non-compacted - Tribal shares left with the IHS on a permanent or interim basis and can be of benefit to the common good or the individual Tribal need

Preventive Care - A component of primary care which emphasizes screening and reduction in risk factors in order to avoid the more elaborate technologies sometimes

necessary for cure. The focus with preventive care is the causes of morbidity and mortality will be foreseen and prevented.

Primary Care - Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them and at a cost that the community can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process. (World Health Organization, 1978).

Privatize - To obtain supplies or services from private sector sources.

Public Health - Organized community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the scientific core of epidemiology. The core functions of public health agencies are: assessment, policy development, and assurance.

Quality Care - Care that conforms to accepted principles of medical science, is provided in a timely and sensitive manner, involves the patient in informed participation and produces optimal improvement in his/her health. Quality care also emphasizes health promotion and disease prevention, makes efficient use of technology and is sufficiently documented to allow continuity and evaluation.

Reservation State - A state in which IHS has responsibilities for providing health care to AI/AN.

Savings - Resources gained as a result of restructuring proposed by the IHDT for reallocation into critically needed patient and community services at I/T/Us.

Service Unit - The local administrative unit of IHS.